FRAUD IN THE MEDICARE PROGRAM

HEARINGS

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

FORT LAUDERDALE, FLORIDA, JULY 30, 1990
WASHINGTON, D.C., SEPTEMBER 25, 1990

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FRAUD IN THE MEDICARE PROGRAM

MONDAY, JULY 30, 1990

House of Representatives,
Committee on Ways and Means,
Subcommittee on Oversight,
Washington, D.C.

The subcommittee met, pursuant to notice, at 8:05 a.m., in chambers at 100 North Andrews Avenue, Fort Lauderdale, Fla., Hon. J.J. Pickle (chairman of the subcommittee) presiding.

[The press releases announcing the hearings follow:]

FOR IMMEDIATE RELEASE
FRIDAY, JULY 27, 1990

PRESS RELEASE #32
SUBCOMMITTEE ON OVERSIGHT
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1105 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-5522

THE HONORABLE J. J. PICKLE (D., TEXAS), CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A FIELD HEARING IN FORT LAUDERDALE, FLORIDA, ON MEDICARE FRAUD

The Honorable J. J. Pickle (D., Texas), Chairman of the Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a field hearing in Fort Lauderdale, Florida, on Medicare fraud. The hearing will be held on July 30, 1990, in the Fort Lauderdale City Commission Chamber, 100 North Andrews Avenue, Fort Lauderdale, Florida, beginning at 8:00 a.m.

The Subcommittee hearing will focus on reports of a Medicare fraud scheme in the Fort Lauderdale area. Testimony will be received from local residents and officials who were involved in the detection and exposure of "free screenings" for cholesterol offered at mobile testing facilities at sites with sizeable populations of low-income elderly people, such as adult day care centers or housing communities for the aged. After completion of an initial screening, follow-up tests were recommended for many of the patients, to be performed immediately by the same mobile testing facility. Patients who had follow-up tests were told that the additional procedures would not cost them anything, because Medicare would cover the cost of follow-up tests. They were also told that test results would be sent to their primary care physicians. It now appears that follow-up tests were quite expensive and were ordered only for Medicare participants; that the follow-up tests may well have been unnecessary; and that the patients' primary care physicians were never notified of either the screening or the follow-up test results.

Representatives of the Office of Inspector General, Department of Health and Human Services, have also been invited to testify before the Subcommittee. This testimony will focus on major Medicare fraud problems, both in Florida and nationwide, including fraudulent practices by mobile laboratories and in the durable medical equipment industry. The Inspector General is responsible for conducting civil and criminal investigations of alleged wrongdoing in the Medicare program. In fiscal year 1989, audits, investigations and inspections undertaken by the Inspector General's office resulted in an estimated savings of $3.28 billion for the Medicare program.

In announcing the hearing, Chairman Pickle stated: "Medicare fraud is a growing national problem. With its concentration of senior citizens, the south Florida area is especially fertile ground for Medicare fraud schemes. Apparently, the real purpose of some free screening schemes is not to identify medical problems, but rather to identify Medicare beneficiaries. In addition to cheating the Medicare system, these schemes cause a great deal of distress for people who are told that they need to undergo medical tests.

"At the hearing in Fort Lauderdale, we will hear from some of the Medicare beneficiaries victimized by a 'free testing' scheme and learn how their voluntary efforts assisted Federal and State officials in the exposure and investigation of this fraud. Hopefully, this hearing will alert others about the existence of Medicare scams and the steps they should take if they are victimized by fraud. I also hope to learn what steps Congress might be able to take to assist in detection--or, better yet, elimination--of Medicare fraud schemes."

(MORE)

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Because oral testimony at the hearing will be presented by invited witnesses only, interested parties are encouraged to provide written statements for consideration by the Subcommittee and for inclusion in the printed hearing record. Persons submitting written comments for the record of the printed hearing should submit six (6) copies by the close of business Monday, August 13, 1990, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, room 1102 Longworth House Office Building, Washington, D. C. 20515.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

FOR IMMEDIATE RELEASE
MONDAY, SEPTEMBER 24, 1990

PRESS RELEASE #35
SUBCOMMITTEE ON OVERSIGHT
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1105 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-5522

THE HONORABLE J. J. PICKLE (D., TEXAS), CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON MEDICARE FRAUD

The Honorable J. J. Pickle (D., Texas), Chairman of the Subcommittee on Oversight, Committee on Ways and Means, U. S. House of Representatives, announced today that the Subcommittee will hold a hearing on Medicare fraud. The hearing is scheduled for Tuesday, September 25, 1990, beginning at 1:30 p.m., in the main Committee hearing room, 1100 Longworth House Office Building. Invited as witnesses at the hearing are representatives from the Office of Inspector General, Department of Health and Human Services, and the Office of the Administrator, Health Care Financing Administration.

The hearing is part of the Subcommittee's continuing effort to examine waste, fraud and abuse in Federal programs under the jurisdiction of the Committee on Ways and Means. In addition, the hearing is being held to follow-up on a hearing held by the Subcommittee in Fort Lauderdale, Florida, on July 31, 1990. At that hearing, the Subcommittee heard testimony about a Medicare fraud scheme involving mobile laboratories that offered to give groups of senior citizens free cholesterol screenings. After the screenings were completed, patients were advised to have follow-up tests. Patients were told that they need not worry about the costs of follow-up tests, as Medicare would cover their costs. In most instances, patients never saw the results of these follow-up tests. Medicare, however, paid out thousands--perhaps millions--of dollars for the tests.

In announcing the hearing, Chairman Pickle stated: "In Fort Lauderdale, the Subcommittee saw how easy it can be to defraud the Medicare system. We also saw how hard it can be to catch the fraud. More than a year has elapsed since the fraudulent free cholesterol-testing scheme was identified, but no penalties, either civil or criminal, have been imposed upon the persons or the laboratories involved. At our hearing, we want to find out why it takes so long to identify and close down these fraudulant operations, and to learn exactly what has been done to address the situation in Florida and elsewhere.

"The situation in Fort Lauderdale is not unique. Medicare fraud is a problem nationwide. Because of the amount of money--more than $100 billion this year--that's being spent on the Medicare program, and because of the high potential for fraud and abuse in this program, the General Accounting Office has identified questionable Medicare claims as a "high risk area" that could result in substantial Federal losses. We have to make sure that every Medicare dollar is used for health care. At the hearing, we'll explore what can be done to better detect and deter fraud."

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Because the oral testimony at the hearing will be presented by invited witnesses only, interested parties are encouraged to provide written statements to the Committee for the printed hearing record. Persons submitting written comments should submit (6) copies by the close of business, Friday, October 26, 1990, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, room 1102 Longworth House Office Building, Washington, D.C. 20515.

(MORE)

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

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2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
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4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

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Chairman PICKLE. We would ask the subcommittee to please come to order, and we will ask our guests to take their seats. Good morning to you. The Oversight Subcommittee of the Committee on Ways and Means is pleased to be here in Fort Lauderdale this morning, the home district of our colleague, Clay Shaw, who is one of the most respected and recognized Members of the House of Representatives and who is a member of this subcommittee. I particularly want to pay my respects to Congressman Shaw because it was through his direct, personal intervention that the subject of today's hearing was brought to the public's light. So we are pleased that you have invited us to come here, Mr. Shaw, and we are glad to be here this morning.

Now, by way of a background material, let me outline some of the basic facts and the reasons for this hearing. We are here today as part of the work of the Ways and Means Committee of the House of Representatives. There are over 20 standing committees in the House, and it is the job of these committees not only to consider changes in our laws, but also to evaluate the laws we already have enacted. In other words, to oversee these laws, to see whether they are effective and if they are properly functioning. The Ways and Means Committee, on which Mr. Shaw and I sit, has jurisdiction over taxes and certain spending matters, including Medicare. The Oversight Subcommittee is charged with the responsibility of looking into how the laws under the Ways and Means Committee's jurisdiction are functioning and where, if necessary, recommendations should be made for the improvement of these laws.

So today we are in Fort Lauderdale to look at the issue of Medicare fraud. The Oversight Subcommittee has been interested in this subject for some time. We held hearings on Medicare fraud starting back in 1977. Florida is an especially fitting sight for hearing on Medicare fraud, because Florida ranks number 1 in the Nation in the percentage of the State population enrolled in Medicare. So Floridians are major beneficiaries of the Federal Medicare program, a program which will spend over $100 billion this year. Any time the Federal Government is paying out that kind of cash, there are sure to be con artists who will try to pick our pockets to line their own pockets.

We selected Fort Lauderdale at the suggestion of Congressman Shaw, because he was personally instrumental in uncovering and alerting the public to a scheme in this area to milk the Medicare program. Under this scheme, mobile labs, offering supposedly free screenings for cholesterol, went to a number of senior citizen centers. After the initial screening, additional tests were performed. However, the real screening taking place was to find out whether people had Medicare coverage.

It turns out that everybody for whom these additional tests were recommended just happened to be covered by Medicare. Medicare was billed and paid out thousands of dollars for these tests. If there is a moral to this story about free testing, perhaps it is that you should look a gift horse in the mouth. In fact, you ought to maybe look at his eyes, ears, nose and throat while you are at it.

I know you know that this country has a serious budget crisis. The deficit is now projected to be over $160 billion. The decisions that we will have to face to reduce this budget deficit are not easy.

Resources are going to be stretched very thin. Everyone is going to be asked to make sacrifices, and all the segments of the population will feel the effects, including our growing elderly population. But there is one place where the budget axe can fall and benefit all Americans, and that would be to eliminate Federal spending due to fraud, waste and abuse in Government programs. Now today we are going to hear from a lot of these people who have been directly involved in this overall work.

That is my preliminary statement. I am going to ask Congressman Shaw if he would like to make a statement before the hearing starts. Mr. Shaw.

Mr. SHAW. Yes, I would. Thank you, Mr. Chairman. I have a prepared statement which I would ask unanimous consent to place in the record.

Chairman PICKLE. Without objection.

Mr. SHAW. Mr. Chairman, I want to thank you for coming down to Fort Lauderdale. Mr. Pickle came in from Texas last night, and I can tell you, in January and February it is easy to get members to come down for a hearing in Fort Lauderdale, but the end of July, you know that is strictly dedication.

Mr. Chairman, we in Fort Lauderdale in Broward County have some wonderful residents who are very concerned about not only the benefits they receive, but also to be sure that the government is getting a square deal in working with the providers of Medicare, as well as other Federal agencies.

In this particular situation, this matter was called to my attention by a few constituents whom I spoke with. It became very clear that a pattern had emerged. We found out during our investigation, which was headed up by Peggy Kiser and others, that a health care provider number is actually easier to come by than a VISA card. That was rather shocking to us. As you and I discussed late last night, Medicare is rapidly becoming one of the major expenditures for the Federal Government, and the occasion and the possibility of fraud are just rampant. I think during this hearing that we are going to not only develop the pattern for abuse, but I also think that some of the answers and some of the solutions will become rather obvious to us.

Again, I very much appreciate your coming down here. I think the hearing is going to be very beneficial, and I have no doubt that when we return to Washington, that we will be armed with some good ideas for new legislation and new solutions to a problem that is, I think, just beginning to emerge and could have horrendous implications if we do not very quickly get it reined in. And again, I thank you for coming down, and let me not forget to thank the city of Fort Lauderdale for allowing us to use this hearing room. I spent many years in here as a city commissioner, as a mayor, and I always feel like coming home to this building is like, indeed, coming home. Thank you, Mr. Chairman.

[The opening statement of Congressman Shaw follows:]

OPENING STATEMENT OF HON. E. CLAY SHAW, JR.

I want to commend Chairman Jake Pickle for bringing the Oversight Subcommittee down to Fort Lauderdale to investigate what is becoming a nationwide Medicare scam. It is clear to me that Florida has become the "testing" ground for Medicare fraud schemes, due to the concentration of "vulnerable" elderly citizens. In fact, over 18 percent of the total population of Florida receive Medicare benefits.

Back in February, I was informed of a sinister scheme involving Mobile Medical Labs that performed unnecessary and expensive tests on literally hundreds of unsuspecting elderly people. This outfit, which operated under the "Healthy Heart" name as well as five others, didn't count on the resourcefulness of the elderly constituents here in my district. We will hear today from four constituents, including two Medicare beneficiaries, who took upon themselves to investigate and uncover this scandal. I commend them for their efforts.

When I announced our investigation into this matter, I said that I would seek action in Congress to close the loopholes that allow fraudulent bills to be submitted to Medicare. We hope to learn today from the HHS Inspector General some common sense ways to prevent abuse of the system. In particular, I am concerned at the ease with which mobile labs and durable medical equipment companies can get Medicare provider numbers—in fact, it's easier to get a provider number than it is to get a VISA card. I also think that we need a better system in place to screen claims more completely for anomalies. We will hear from representatives from Blue Cross and Blue Shield of Florida later on this morning on these issues.

I want to close, Mr. Chairman, by putting out a word of warning to our Medicare beneficiaries. First, remember that nothing is free. Second, never give out your Medicare number to anyone unless you know what it is to be used for. Finally, don't take any medical equipment or test not recommended by your regular doctor.

Thank you again, Mr. Chairman, for coming down this morning. I look forward to hearing from our witnesses.

Chairman PICKLE. We thank you, Congressman Shaw, and thanks again for the invitation. The Chair would like consent at this time also to insert for the record certain documents and materials that we have gathered in connection with the hearing. Without objection, they will be included at this time.

[The documents and materials follow:]

OFFICE OF INSPECTOR GENERAL

OFFICE OF EVALUATION AND INSPECTIONS

Richard P. Kusserow
INSPECTOR GENERAL

MOBILE HEALTH SERVICES

OEI-05-89-01331 JULY 1990

EXECUTIVE SUMMARY

PURPOSE

This inspection provides a national overview of the types and prevalence of mobile health services, the quality of these services, and the degree of regulation.

BACKGROUND

This is one in a series of reports on mobile health services. Two other reports describe: (1) the prevalence, conduct, and regulation of public cholesterol screening; and, (2) mobile health care providers that serve medically underserved and uninsured populations in public settings, or make physician housecalls.

We conducted these studies in response to a request by the Chairman of the House Subcommittee on Regulation and Business Opportunities. They provide information concerning mobile health services: services offered outside the traditional settings of a hospital, clinic, or physician's office. This report provides a preliminary look at the mobile health services industry. An in-depth study would require a great deal more research, given the wide variety of services and providers.

The services described in this study share one common characteristic: they bring healthcare to the people. Public screening reaches millions in community settings across the country. Providers using specially equipped vehicles go to employees on the job, visit the chronically ill in their homes, and park at migrant camps, homeless shelters, and rural crossroads. Large, high-tech equipment is loaded on trailers and shared by hospitals.

This study reveals that the mobile health services industry is changing and expanding. At present, public cholesterol screening is the only mobile health service which is both prevalent and nationally visible. While it is not clear whether or to what extent the industry is growing, some mobile health services appear promising in terms of providing health care in new and possibly cost-effective ways.

METHODOLOGY

We conducted an extensive literature review and held telephone discussions with 241 persons, including Federal and State regulators; persons from professional associations, State hospital associations and State consumer fraud agencies; experts; equipment and vehicle manufacturers; and providers of mobile health services. Most of the information is qualitative in nature and was gathered from a wide variety of sources. All had some knowledge of a particular service but none had a broad perspective on the industry as a whole. Few mobile health service providers register or are licensed as such, and no national or State database exists to track them. Hence, locating, much less systematically assessing, these services is difficult.

FINDINGS

Providers Deliver All Kinds Of Health Services In Mobile Settings. The Prevalence Of Mobile Health Services Is Difficult To Determine.

- Mobile health services are as diverse as public cholesterol screening, cardiac catheterization, and physician housecalls.
- Sponsors of mobile health services range from hospitals and health departments, to private entrepreneurs, to civic and professional groups.

Regulation Of Mobile Health Services Varies Widely For Some Services And Is Non-Existent For Others.

- Only Kentucky specifically regulates "mobile health services," as such.
- Most State and Federal regulation varies according to type of service, type of provider, place of service and/or cost of equipment.

Respondents Agree That Mobile Health Services Can Improve Access To Care. However, They Raise Questions Related To The Quality And Costs Of Such Services.

- There is concern that mobile testing may be compromised by inadequate quality assurance programs and ill-trained staff.
- There is no consensus on whether mobile health services are cost-effective.
- It is not clear whether mobile health services are any more prone to fraud and abuse than traditional health services.

RECOMMENDATIONS

The Public Health Service (PHS) Should Work With The States To Develop A Process For Identifying Emerging Mobile Health Services And Their Providers.

The PHS And The Health Care Financing Administration (HCFA) Should Develop Priorities And Protocols For Regulating Various Types Of Mobile Health Services.

AGENCY COMMENTS:

Both PHS and HCFA concur with our recommendations. The HCFA believes that PHS, with its technical expertise and resources should take the lead. The PHS agrees, but before developing priorities and protocols will review the available imperial research data and governing legislative authorities to ensure protocols that contained defined measures of quality of care.

We wish to thank those in PHS and HCFA who commented on the report. The complete texts of their comments are contained in Appendix B. Several editorial changes were made based on PHS's comments.

INTRODUCTION

PURPOSE

This inspection provides a national overview of the types and prevalence of mobile health services, the quality of these services, and the degree of regulation.

BACKGROUND

This is one in a series of reports on mobile health services. Two other reports describe: (1) the prevalence, conduct, and regulation of public cholesterol screening; and, (2) and mobile health care providers that serve medically underserved and uninsured populations in public settings, or make physician housecalls.

We conducted these studies in response to a request by the Chairman of the House Subcommittee on Regulation and Business Opportunities. They provide information concerning mobile health services: services offered outside the traditional settings of a hospital, clinic, or physician's office. This report provides a preliminary look at the mobile health services industry. An in-depth study would require a great deal more research, given the wide variety of services and providers.

While it is difficult to generalize about an industry that is so diverse, all of the activities described in this study share one common characteristic: they bring healthcare services to the people. Public screening, for example, reaches millions in community settings across the country. Providers using specially equipped vehicles go to employees on the job, visit frail, chronically ill elderly in their homes, and park at migrant camps, homeless shelters, and rural crossroads. Large, high-tech equipment, like that used for magnetic resonance imaging (MRI), is loaded on trailers and shared by hospitals.

Demand for mobile health services is driven by the interaction of public policies, social trends, the entrepreneurial spirit and technological advances. Federal health promotion policies have made the public aware of health issues and interested in taking an active role in their own health care, leading to interest in public screening. Public demands for ease and convenience at low cost have also fostered the growth of mobile services. Providers are seeking new ways to provide services in order to recoup revenue lost in part due to Federal cost containment efforts. Private entrepreneurs show increasing interest in providing health services traditionally offered by hospitals or clinics. Finally, mobile health services would not be possible without technological advances that have produced equipment adaptable to use in mobile settings.

This study reveals that the mobile health services industry is changing and expanding. At present, public cholesterol screening is the only mobile health service which is both prevalent and nationally visible. While it is not clear whether or to what extent the industry is growing, some mobile health services appear promising in terms of providing health care in new and possibly cost-effective ways.

METHODOLOGY

We gathered information for this inspection through an extensive literature review and telephone discussions with 241 persons. By necessity, most of the information is qualitative in nature and was gathered from a wide variety of sources. All had some knowledge of a particular service, but none had a broad perspective on the industry as a whole. Few mobile health service providers register or are licensed as such, and States monitored only a very few providers such as x-ray facilities. Hence, locating, much less systematically assessing, these services is difficult.

The literature reviewed consisted of Federal and State laws, regulations and guidelines, research papers, studies, reports and newspaper articles. The people we talked with included:

- 119 regulators from all 50 States and the District of Columbia responsible for oversight of health care services;

- 25 Department of Health and Human Services officials, especially in the Public Health Service (PHS), including the Food and Drug Administration (FDA) and the Health Care Financing Administration (HCFA);
- 5 officials from the Occupational Safety and Health Administration (OSHA), Nuclear Regulatory Commission (NRC), Department of Transportation, and Environmental Protection Agency;
- 2 persons from the Office of Technology Assessment and the General Accounting Office;
- 37 persons from 17 professional associations, 10 State hospital associations and 5 State consumer fraud agencies;
- 14 experts with special perspectives on the issue;
- 5 equipment and vehicle manufacturers; and
- 34 providers of mobile health services.

We asked respondents to describe the mobile health services of which they were aware, and their prevalence. Even State regulators often relied on everything from first hand knowledge, advertisements and word of mouth, to State licensing or registration of providers or equipment to answer our questions. Some responses were only guesses or gut reactions. Even when numbers were given, they reflected only those mobile services of which respondents were aware, not necessarily all those operating in the State in question.

FINDINGS

Providers Deliver All Kinds Of Health Services In Mobile Settings. The Prevalence Of Mobile Health Services Is Difficult To Determine.

- Health services as diverse as cholesterol screenings in shopping malls (by far the most prevalent type of mobile health service), cardiac catheterization and physician housecalls are being delivered in mobile settings.

Public Screening

Public Screening is the most nationally visible and prevalent type of mobile health service. By public screening we mean testing that is not requested by a doctor or is performed in a public setting. It is occurring in all 50 States and the District of Columbia. However, due to the "here today and gone tomorrow" nature of many public screenings, the number of screening providers operating in the nation is unknown.

Many screening providers set up in highly trafficked areas such as shopping malls, grocery stores, pharmacies, and even State Fairs. Such public screenings are often called "health" or "wellness fairs." In addition to actual screening tests, such fairs usually involve self-reporting from participants on their life style in order to develop a health risk appraisal.

Other providers also offer screening tests, usually as part of an array of health services targeted at a special population such as farm workers, runaways or employees. They set up at locations such as migrant camps, city street corners or industrial sites.

The public screening tests offered in mobile settings are very diverse, ranging from (1) blood tests to identify high blood cholesterol, diabetes, acquired immunodeficiency syndrome (AIDS), sickle cell anemia, pregnancy, or liver or kidney dysfunction; (2) x-rays, such as mammography to detect breast cancer; (3) pulmonary function tests to identify impaired lung function; and, (4) foot or dental examinations.

The most prevalent type of mobile screening service at this time is public cholesterol screening, which we describe in detail in another report entitled "Public Cholesterol Screening." Mobile mammography screening for breast cancer is also growing in prevalence. Four respondents reported that their States are, in the words of one, "flooded with mammography units." Some respondents believe that mobile mammography screening will continue to grow.

Diagnostic Services

We also learned of a few providers who conduct a broad array of screening and diagnostic testing out of specially-equipped trucks or vans. These so-called multiphasic providers are for-profit entities, both private companies and hospital affiliates. The term "mobile" is particularly appropriate to them, since many have regional or even national service areas.

Multiphasic providers contract with entities such as unions, public and private organizations, or employers (such as heavy industry, State or Federal governments, professional sports teams, and even hospitals). They set up anywhere the client needs the service, whether a coal mine, industrial site or parking lot. Their clients often request such services in order to comply with OSHA standards, and providers tailor their services accordingly. A typical "menu" of services may include a patient history, height, weight, vision and hearing tests, blood pressure, blood tests, urinalysis, electrocardiogram, tonometry (for glaucoma), spirometry (for lung capacity), and a chest x-ray.

Mobile X-ray and Imaging

Mobile x-ray providers exist in almost all of the States. They most often screen the homebound or those in nursing homes for tuberculosis. However, some travel to industrial sites, such as a tire plant, or even gold or uranium mines, to screen employees for lung cancer or other diseases resulting from exposure to hazardous materials, like asbestos.

Mobile imaging services, specifically mammography and computerized axial tomography (CAT), which can detect tumors or bleeding in the brain or other body organs, exist in nearly half of the States. Ultrasound and MRI are other examples of such services. Providers station trucks, trailers or coaches housing this equipment outside the hospital or clinic requiring these diagnostic services for their patients.

Other Services

In a few States, more obscure yet innovative diagnostic procedures are also being performed in vehicles, although the potential risks associated with them limits the choice of setting to a hospital or clinic, where surgical and acute care backup is available. Twenty percent of the States report having a mobile lithotripter (which uses shock waves to shatter kidney stones) either operating or based in the State. The equipment is housed in the trailer of an 18-wheel truck and transported to hospitals or clinics. Cardiac catheterization, where a plastic tube is inserted into a blood vessel of the heart, is also being performed on a mobile basis. Only a few States knew of this type of mobile service. An article in *Part B News* (vol. 3, No. 10, 9/11/89) estimated that there are less than 100 freestanding cardiac catheterization labs. Some of these may be mobile. The article projects an expansion in freestanding labs because they are now allowed to bill HCFA directly rather than through a hospital, as in the past.

Housecalls may be making a comeback in America. Though few in number at this time, some providers have developed a "roadside manner" by using vans to bring not just the doctor, but the doctor's office, to a patient's home. Also, a few providers are using vans to take an array of health services to medically underserved and uninsured groups in public settings. Such services reach people who, for various reasons, have problems accessing care. Respondents see them as an alternative to no care at all, or to emergency room services. We describe both of these innovative types of mobile services in a separate report entitled "Health Care on Wheels."

- Sponsors of mobile health services vary greatly, from hospitals and health departments, to private entrepreneurs, to civic and professional groups.

Health departments at all levels of Government, from Federal to local, provide mobile health services to their employees, the public at large, or targeted groups, as a public service.

Hospitals provide services in mobile settings, often as a public service or as a public relations or marketing strategy, to enhance their public image and increase their visibility. Seven out of 10 respondents from State hospital associations say that hospitals are offering public screening of some sort, to draw patients into the hospital for more profitable services. Hospitals may also contract out their services on a mobile basis to other entities, such as a nursing home, skilled nursing facility or even an employer or union.

Hospitals sometimes turn to mobile services as a cost containment measure, sharing equipment or contracting for a service with another entity, often a physician or physician group practice. They do this either because: (1) the hospital's utilization needs do not justify the expense of purchasing a highly expensive piece of equipment, like a lithotripter; or, (2) the State has certificate of need (CON) utilization requirements that one hospital is unable to meet, but that two or more hospitals can meet through sharing equipment. (See appendix A for a description of the CON process.)

Some respondents believe that as rural hospitals continue to close or limit services, remaining hospitals will increasingly turn to "putting their services in vans and sending them out to every town on every third Tuesday" in order to meet the routine health care needs of their communities. One respondent said that hospitals that fail to capitalize on this opportunity will lose this market niche to more enterprising providers.

Physicians and independent clinical laboratories are delivering mobile health services to make a profit. So are private entrepreneurs, both with or without a health care background. One respondent said that private entrepreneurs, showing an "amazing interest in health care," are increasingly providing health services traditionally offered by hospitals or physician clinics, such as screening, multiphasic testing or MRI. Another remarked, "If it's profitable, people will be out there doing it."

Unions and employers, either independently or under contract with other entities such as hospitals or private entrepreneurs, provide mobile health services to their members or employees. They do so as a company benefit or as a preventive health measure, to comply with OSHA requirements for mandatory testing for occupational exposure to environmental hazards.

Public and private agencies, community health centers and organizations such as the American Red Cross, the American Hospital Association, and even the American Medical Association may sponsor or deliver mobile health services, primarily as a public service.

Civic and professional groups are also sponsoring mobile health services, often as fundraisers. Insurance companies provide mobile services to assess the health of people seeking coverage.

Regulation Of Mobile Health Services Varies Widely For Some Services And Is Non-Existent For Others.

- Kentucky is the only State that specifically regulates "mobile health services," as such.

Kentucky regulates mobile health services through their CON process. Physician private practices and public service corporations are exempted. The State was experiencing an increasing variety of mobile health services and passed this law to help ensure State regulatory oversight over them. The regulation is very broad, providing minimum licensure requirements for entities providing such services as "mobile diagnostic imaging and examination services, mobile treatment services, and any other medical or dental services provided through the use of a mobile vehicle or performed at various locations."

- Most State and Federal regulation varies according to type of service, type of provider, place of service and/or cost of equipment.

For many mobile services, existing regulation addresses the general characteristics of the service, rather than its mobility. For example, Federal regulation covers x-ray services regardless of whether they are stationary or mobile. States vary in both the intent and extent of oversight of various medical services. They to regulate to: (1) comply with Federal mandates; (2) protect public health and safety; and, (3) contain costs. The extent of a State's regulatory oversight is frequently dependent on the funds and staff it has available, or on the level of legislative interest that can be generated in favor of regulation.

Mobile X-ray and Nuclear Medicine

Mobile x-ray is the most regulated type of mobile health service, and is regulated by the Federal Government and, in some form, by all but one State (Wyoming). On the Federal level, both equipment and providers are subject to some degree of oversight. The type and extent of State oversight vary widely.

On the Federal level, HCFA certifies portable x-ray providers seeking Medicare reimbursement. The FDA regulates the manufacture and installation of x-ray equipment, although there are no special provisions relative to mobile units per se. X-ray equipment manufactured after August 1, 1974 (pursuant to the Radiation Control for Health and Safety Act of 1968) is subject to FDA radiation safety performance standards. To ensure compliance, FDA reviews documentation from the manufacturer and may also perform on-site inspections of the manufacturer's facility, test the product, or inspect equipment at a purchaser's place of business.

The FDA also requires that manufacturers and x-ray assemblers file a report each time they assemble an x-ray system, although there are no special provisions relative to mobile units. According to a staff person from FDA, the agency aims to review between 25 to 30 percent of all newly-assembled systems within a year of assembly, and usually contracts out this review function to a State.

State regulation of mobile x-ray runs the gamut - from minimal equipment safety standards to extensive equipment and operator safety standards, with mandated operator qualifications and quality assurance programs. The frequency of State on-site inspections of equipment ranges from annual, to every five years, to sporadic. One State respondent admitted that their on-site inspections consisted of only "very cursory checks" and that they were only "looking for gross problems." Eight State respondents admitted that some x-ray equipment in their States has never been inspected.

State-mandated quality assurance programs and operator qualifications for mobile x-ray services are neither prevalent nor universal. Staff range from certified radiological technicians (those who have passed the American Registry of Radiological Technicians exam or are certified by the State's to office assistants with no special training. One State respondent, echoing the concerns of several others, called the lack of quality assurance "a sore spot", and the issue of staff training "a thorn in my side . . . an MD gives a couple of lessons to someone off the street and they're qualified."

Mobile nuclear medicine services, which involve the use of radioactive byproduct material, are regulated by either the NRC or one of the 29 so-called "Agreement States", that is, States that have agreed to enforce, at a minimum, NRC regulations concerning such services. These States have the authority to license radioactive materials used or possessed within their borders. Oversight consists of health and safety surveys concerning the transportation, use, and disposal of radioactive by-product material.

Mobile Screening

Despite their prevalence, most mobile screening providers are unregulated. States more often than not consider screening tests to be a health assessment rather than the practice of medicine, since the purpose is to provide information on health status or identify risk factors rather than diagnose and treat a condition or illness.

Only some States have mammography screening guidelines for providers. Few States actually prohibit self-referral. One State, which does prohibit self-referral, also has a State law whereby "medical liability" is incurred by the screening radiologist if the patient does not have a primary care physician. The State respondent credited this law with minimizing indiscriminate mammography screening in his State, such as that going on in neighboring States, saying that once a provider finds out about this law, "they don't want to get involved."

Major Medical Equipment

Major medical equipment used in mobile settings (i.e., lithotripters, MRI, CAT scanners and cardiac catheterization units) is most often regulated through States' CON process. This process requires that facilities such as hospitals justify utilization needs to the State in order to purchase major medical equipment whose acquisition costs exceed a State pre-determined dollar amount. (See appendix A for a further description of CON.)

There are gaps in regulation under CON, however. For example, regulation is sporadic because CON is slowly being phased out and exists in 38 States. Also, one major drawback of CON is that it does not apply to all mobile health care providers or services. For instance, one State regulates medical equipment costing $300,000 or more, while another has set the acquisition cost criteria at more than $500,000. Consequently, State monetary limitations exclude some major medical equipment from regulation. Also, as technology advances, the cost of medical equipment often correspondingly decreases.

Maryland has approached regulation of major medical equipment somewhat differently than other States. For example, since CON exempts some entities, such as physician's offices, from coverage, the State has attempted to make regulation universal. They have replaced CON with a licensure program applicable to all major medical equipment costing more than $600,000, whether owned by a hospital or another entity such as a private physician group or freestanding clinic. Maryland also attempts to regulate both the quality of use and the growth of major medical equipment regardless of setting.

While Maryland's program was initially conceived as part of a cost containment initiative, the State believes it has evolved into an effective quality assurance tool. Licensees are required to have a quality assurance program to ensure appropriate qualifications for all supervisors and operators of the equipment, and to provide for continuing education for all staff. They must also develop a system using objective criteria for both quality and appropriateness for the ongoing monitoring and evaluation of use of the equipment.

Mobile Laboratory Services

On the Federal level, mobile clinical laboratory services, regardless of site or volume of testing, are regulated by the Clinical Laboratory Improvement Amendments of 1988 (CLIA of 1988). The HCFA will now review mobile clinical laboratories for certification. Prior to CLIA of 1988, these types of entities were not federally regulated. (Appendix A contains a description of CLIA of 1988.)

Twenty-four States would regulate any mobile clinical laboratory services through existing clinical laboratory regulations, although few State respondents were aware of the existence of such services. Regulation is varied, although mobile laboratories would qualify as a hospital, physician or independent clinical laboratory and, therefore, have to meet the same requirements as their stationary counterparts.

Mobile Ultrasound

Mobile ultrasound equipment is regulated by only one State (Kentucky), even though other States have the statutory authority to regulate them. Some State respondents believe that ultrasound is not regulated either because States lack the money, staff or time to regulate, or because ultrasound has not been demonstrated to be potentially harmful to the patient.

Devices Used in Mobile Settings

- In the Federal arena, FDA approves medical devices for market, but there is no special review for devices used in mobile settings. States regulate the use of medical devices once they are approved for market.

The Medical Device Amendments of 1976 require that all medical devices be reviewed by FDA prior to marketing. However, there are no special provisions for the review of either portable devices or devices which can be used in mobile settings. Staff at FDA point out that, thanks to rapid technological advancement, many devices once used only in hospitals are increasingly being used in either the home or other non-traditional settings. (See appendix A for a description of the device review process.)

The use of medical devices, once they are approved for marketing, constitutes the practice of medicine and is regulated by States. The FDA imposes no special requirements on the use of equipment in mobile settings, although it has two special problem-reporting systems which are intended to target life-threatening problems related to the labeling or misuse of a device, no matter where used.

The Office of Inspector General is currently conducting internal control reviews of FDA's device review processes, as well as conducting an inspection on the subject of problem medical devices.

- The FDA also is responsible for protecting the public from unnecessary exposure to radiation from electronic products, some of which may be medical in nature.

The Radiation Control for Health and Safety Act of 1968 assigns responsibility to FDA for setting and enforcing radiation safety performance standards for electronic products, that is, all products or equipment capable of emitting ionizing or non-ionizing radiation, or sonic, infrasonic, or ultrasonic waves. Such products may be medical--such as diagnostic or cabinet x-ray systems, laser products or ultrasonic therapy equipment--or non-medical, such as microwave ovens.

The standards prescribe approaches to control radiation emissions. There are no standards specific to the use of the equipment in mobile settings.

Respondents Agree That Mobile Health Services Can Improve Access To Care. However, They Raise Questions Related To The Quality And Costs Of Such Services.

- According to respondents, the greatest benefit of mobile health services is that they provide access to health care.

Public screenings provide a convenient way for large numbers of people to undergo preliminary health risk assessments at a low cost. For many people, it can be a first step in seeking medical care.

Mobile health services can either serve to motivate people to see a doctor, or in some cases, actually be the doctor. Providers who bring services to the homebound, or to the medically underserved and uninsured in public settings, target these populations to bring them into the health care system. These types of services are described more fully in a separate report entitled "Health Care on Wheels."

Mobile health services may also help alleviate gaps in a community's health care system. They may replace services lost by closures of small rural hospitals or expand a small hospital's diagnostic testing capabilities, since they permit joint ownership or contracted services where there is insufficient capital or patient population to justify a permanent installation.

- Respondents are concerned that mobile testing may be compromised by inadequate quality assurance programs and ill-trained staff.

The major concern of respondents in this study has to do with the quality of testing conducted in mobile settings. Many States do not monitor mobile operations, raising questions in the minds of respondents about the safety and accuracy of mobile testing. Some State respondents suspect that mobile operations lack adequate supervision, that units do not have one qualified, accountable person in charge. And they express concern about whether quality assurance programs are in place at mobile testing sites. A separate report entitled "Public Cholesterol Screening" discusses these issues in depth as they relate to that type of mobile testing, which is both prevalent and highly visible across the country.

Respondents believe that quality is compromised most by the operators of the equipment, as opposed to the equipment itself. They stress that, in the words of one respondent, "the operator is the key" to quality testing. With the possible exception of hospital-owned or affiliated services, they feel that staff of mobile providers are often inadequately trained. They suspect that some for-profit providers train lay people on-the-job to conduct screenings, finding it too costly to hire highly qualified staff and still make a profit.

One State respondent noted further that, even with "cookbook type" tests, problems can still occur that require trained and experienced staff to detect and correct them. Respondents fear that operators who do not know how to properly use and maintain their mobile equipment may produce poor quality tests, or even unwittingly spread disease by ignoring proper hygienic conditions at test sites.

Some respondents advocate restricting those permitted to conduct mobile testing to only "health care professionals" who are trained to perform specific types of tests. Two respondents expressed the opinion that being a nurse, in and of itself, should not authorize a person to administer tests, since even a nurse may lack test-specific training.

- There is no consensus on whether mobile health services are cost-effective.

Relative to public screening, respondents say that while the public may pay less for a screening test in a public setting than in a hospital or physician's office, many fear that this is at the expense of quality. One State respondent said: "The price is certainly right for the patient." However, another countered: "You get what you pay for."

There were also questions about the effectiveness of public screening in targeting those in need of follow-up. Four State respondents questioned the value of screening which is not targeted to a population at risk. One of them posed the scenario of screening 20,000 people to find only 2 or 3 needing medical attention. They question the cost-effectiveness — to a State who conducts it, and to the public — of random screening that identifies such a small number of people at risk.

Multiphasic providers say that their services are cost-effective for both themselves and their clients because their operations are highly automated, efficient, and serve a high volume of patients, thus reducing the cost per patient. They say further that their services reduce the time lost from work by employees due to testing and prevent the development of major health problems by identifying them early on.

Hospitals may provide mobile health services at a profit or not. However, even if a mobile service operates at a loss, a hospital may continue to offer it in the hopes that it will encourage people to use their hospital.

Some respondents think that the sharing or contracting of expensive mobile health services, such as MRI or CAT scanners, is cost-effective for providers. However, one medical consultant reported that an MRI delivered in a tractor-trailer costs more than the $600 average price for a scan with a stationary MRI unit. Thus, even if these types of services are cost-effective for the provider in allowing the cost of the equipment to be shared, they may not necessarily be so for the patient.

In the case of cardiac catheterization, a change in Medicare reimbursement procedures may lead to cost savings. Freestanding laboratories, some of which may be mobile, can now bill Medicare Part B directly rather than through a hospital outpatient department as in the past. As reported in *Part B News* (vol. 3, No. 10, 9/11/89), HCFA requires that a lab first get a determination from its carrier and peer review organization that the diagnostic services can be performed "appropriately and safely in the facility." The article noted that a HCFA official said that HCFA had become convinced that freestanding facilities could perform the procedure just as safely, and at less expense, than inpatient facilities. It noted further: "Rough estimates put the inpatient cost at about $6,000 and outpatient at $1,700-$2,600 for a left heart catheterization."

- It is not clear whether mobile health services are any more prone to fraud and abuse than traditional health services.

Respondents acknowledge that since mobile providers can set up for only a couple of hours or days in any one place, they may be "wide open for it (fraud)," yet they question whether mobile services are any more prone to fraud and abuse than other health services. Few respondents, including those from State consumer fraud agencies, were aware of specific cases.

In our discussions with Federal investigators, we did learn of a few cases where fraudulent providers have visited sites such as retirement homes, mobile home parks, or health clubs to conduct screening such as "ultrasound scan and body composition" tests, hearing or cholesterol tests, Doppler or echocardiogram imaging, "carotid artery" or other types of vascular testing. They have targeted elderly people and told them that Medicare will pay for the tests. The "patients" later learn that Medicare disallows all or part of the cost because the tests are considered screening rather than diagnostic testing.

Some of these cases have attracted press attention, particularly in Florida and California. One especially significant case resulted in a federal indictment and prison term, and the providers were permanently barred from Medicare. However, a six-agency task force continues to investigate these individuals because they continue to operate, although task force members say that they appear to have abandoned a mobile approach several years ago and no longer bill Medicare.

RECOMMENDATIONS

The PHS Should Work With The States To Develop A Process For Identifying Emerging Mobile Health Services And Their Providers.

The mobile health services industry is not well known or understood, even to State regulators with some responsibility for oversight. Yet this study reveals that health services of all types are increasingly being delivered in mobile settings, and that some of them may offer advantages related to access and cost.

We believe that the first step in learning more about mobile health services is to be able to identify services and their providers. As the Department's lead agency in matters related to health care services, we believe that PHS should assist the States in developing a process for this purpose.

The PHS And HCFA Should Develop Priorities And Protocols For Regulating Various Types Of Mobile Health Services.

Few of the services described in this report are regulated to any significant degree, whether by Federal or State Government. Yet, State respondents in this study raise serious concerns about the issue of quality relative to mobile health services. Furthermore, there are indications that some services are growing in prevalence, especially mobile testing of all kinds, which may already be reaching millions of Americans.

Accordingly, we recommend that PHS and HCFA prioritize specific types of mobile health services and develop regulatory protocols for them. Factors which should be addressed in developing these protocols include: (1) whether regulation is best carried out by State or local Government, or professional associations (for example, the Joint Commission for the Accreditation of Healthcare Organizations); (2) what role is appropriate for the Federal Government; (3) what special regulatory requirements are necessary given the mobile nature of these services; and, (4) what requirements are needed for the oversight of the equipment, provider, and operator for any given service.

For services involving laboratory testing, the development of protocols should be undertaken in conjunction with HCFA's implementation of the Clinical Laboratory Improvement Amendments of 1988.

Agency Comments:

Both PHS and HCFA concur with our recommendations and are willing to work cooperatively to achieve them. The complete texts of their comments are contained in Appendix B.

APPENDIX A

Current Regulatory Oversight Mechanisms for Mobile Health Services

The Clinical Laboratory Improvement Amendments of 1988 (CLIA of 1988)

These amendments brought all clinical laboratories under Federal regulation. Under CLIA of 1988, *all* clinical laboratories, regardless of site or test volume, must meet several requirements in order to obtain a certificate, or license to operate.

Prior to this, title 18 of the Social Security Act required that hospitals and independent laboratories meet certain conditions of coverage in order to receive reimbursement under Medicare and Medicaid. The CLIA regulated laboratories involved in interstate trade. With the passage of OBRA 1990, laboratories, including mobile laboratories, must now be certified under CLIA of 1988.

Each State has its own licensure requirements for clinical laboratories. Some are more stringent than those required by the Federal Government.

The FDA Device Approval Process

The Medical Device Amendments of 1976 require that all models of medical devices not on the market by the date of the amendments be reviewed by FDA prior to marketing in one of two processes: premarket notification (known as 510(k)) or premarket approval. Under 510(k), any device which FDA deems "substantially equivalent" to a device already on the market is not subject to any special testing by FDA. Only a few devices which are life-supporting or sustaining, or which represent a major change in technology, go through the much longer and more extensive pre-market approval process, where they are tested by FDA prior to approval.

The FDA Radiation Control Responsibility

The comprehensive Radiation Control for Health and Safety Act was enacted in 1968 to protect the public from unnecessary exposure to radiation from electronic products. Administration of the law is carried on through the setting and enforcement of performance standards to limit radiation emissions. The standards apply to products offered for sale or use in the United States, whether manufactured in this country or elsewhere.

Performance standards are prescribed for radiation-producing electronic products when FDA determines that Federal regulations are necessary for the protection of the public health and safety. The standards prescribe maximum allowable radiation levels and other approaches to control of radiation emissions without specifying design features.

State Certificate of Need (CON) Programs

The National Health Planning and Resources Development Act of 1974, Public Law 93-641, and its accompanying regulations, required States to implement CON program by July 1, 1978 or be subject to the loss of Federal funds for health planning as well as for other purposes.

The unnecessary construction or modification of health care facilities and duplication of health services were found to be substantial factors in the cost of health care. States developed CON programs to help control the rising cost of health care. They believed that CON would promote effective health planning by avoiding unnecessary duplication of health facilities and services, and would assist in providing quality health care at the lowest possible price.

State CON requirements vary widely, although all programs require that health care facilities justify to the State the need for purchasing major medical equipment or building new additions to, or modifying their facilities. The National Health Planning and Resources Development Act lapsed in 1987. As a result, CON is slowly being phased out and now exists in 38 States, which have continued to use it voluntarily, some of them for quality assurance purposes.

State and Local Regulations

Most health services are regulated in some way by State and/or local governments. This includes regulation of the certification and licensure of various medical professionals.

APPENDIX B

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandu

Date MAY 14 1990

From Gail R. Wilensky, Ph.D.
Administrator

Subject OIG Draft Report: Mobile Health Services, OEI-05-89-01331

To The Inspector General
Office of the Secretary

We have reviewed the subject draft report. This report provides a national overview of the types and prevalence of mobile health services, the quality of these services, and the degree of regulation.

The report recommends that PHS and HCFA should develop priorities and protocols for regulating various types of mobile health services. We believe that PHS, with its technical expertise and resources, should have the lead in developing such priorities and protocols. We would then evaluate PHS' recommendations and apply them as appropriate. As an example of such a collaborative relationship, HCFA consulted with PHS in response to an inquiry about possible Medicare certification of mobile laboratories. We received PHS recommendations on the documentation needed to demonstrate the compliance of mobile laboratories with Federal requirements. We then incorporated these recommendations into the survey instructions that will implement the Clinical Laboratory Improvement Act of 1988. We believe this type of cooperative effort will achieve the goals that OIG is setting forth in its recommendation.

Thank you for the opportunity to comment on this draft report. Please advise us whether you agree with our position at your earliest convenience.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Memorandum

Date MAY - 9 1990

From Assistant Secretary for Health

Subject OIG Draft Report, "Mobile Health Services," OEI-05-89-01331

To Inspector General, OS

Attached are the comments of the PHS on the subject draft report. We are supportive of improved mobile health care service delivery as part of a total system of health care. Our grant-supported State and community health center programs have effectively used mobile health services, particularly helping disenfranchised populations. However, we do have concern about the wide-range of medical practice situations covered in the report which do not differentiate between physician-referred and non-referred screenings.

We concur with the report's recommendations. However, before developing the full array of potential priorities and protocols, we will review the available empirical research data as well as the governing legislative authorities since the protocols will require well-researched and defined measures of quality of care.

James O. Mason
James O. Mason, M.D., Dr.P.H.

Attachment

COMMENTS OF THE PUBLIC HEALTH SERVICE ON THE OFFICE OF THE INSPECTOR GENERAL DRAFT REPORT "MOBILE HEALTH SERVICES" OEI-05-89-01331, MARCH 1990

General Comments

We are in agreement with the overall intent of this report for improved health care services through mobile health care delivery as part of a total system of health care. The State and community programs we have supported through grants for disenfranchised populations, such as the homeless, migrants, and those in rural areas, have used mobile services to meet the critical health care needs. However, it should be recognized that mobile health care service, such as screening programs, must be considered to be part of a total care system, that is, provided in collaboration with primary and tertiary care systems to ensure appropriate follow-up and referral for ongoing specialty care.

We have some concern about the wide range of health care services that are addressed in the report under the definitional grouping of "mobile health care services." We find that the report's groupings may be potentially confusing to the medical community, in particular, if the use of mobile health services for physician-referred, prescription service is construed to be the same as services for non-referred, mass-screening purposes. Such distinctions are important to physicians because of the degree of validity they place on the results. We suggest some refocusing of the findings and recommendations' section of the report to address the adequacy of health care by medical practice situation rather than merely grouping by means of delivery of the services.

We believe that benefits of mobile services should not be overlooked while focusing on perceived problem areas suggested by respondents to the study. For instance, the costs of mobile services may be justified if needy populations are served that would not be reached by fixed care providers on a regular basis. However, considerable judgment has to be employed in the use of mobile health services for screening programs for diseases such as AIDS because of concerns of patient confidentiality and adequacy of the testing procedures.

OIG Recommendation

The PHS should work with the States to develop a process for identifying emerging mobile health services and their providers.

PHS Comment

We concur. PHS' grant programs for community, migrant, and rural health centers provide support for mobile health services as a means of providing critical health care to medically underserved populations.

OIG Recommendation

The PHS and HCFA should develop priorities and protocols for regulating various types of mobile health services.

PHS Comment

We concur. However, before developing such protocols, PHS will review, in concert with HCFA, the available empirical research data as well as the governing legislative authorities. The protocols will require objective measures for evaluating the quality of the services provided in a way that is clinically meaningful. Our experience in evaluating mammography image quality has demonstrated to us that the development of such measures is a complex task.

Technical Comments

1. Page 1, Background

   We believe that OIG's characterization that the mobile health services industry is at an "embryonic stage" is inaccurate. Mobile x-ray screening has been around for decades, first with tuberculosis and now with mammography screening. We suggest that the industry be characterized as changing and expanding.

2. Page 2, Methodology

   The OIG statement that no "... State database exists to track ..." mobile health service providers is inaccurate. The statement should be modified to reflect that some areas of the mobile health service providers (for example, x-ray facilities) are monitored by the States.

3. Page 4, Screening Section

   A statement should be included that non-referred x-ray examinations are forbidden in most States. The exception to this rule is mammography screening. We have worked with the State health departments to eliminate non-referred, mass chest x-ray screening programs for tuberculosis. We are concerned that it would be a step backward if the OIG report could be interpreted in any way

Chairman PICKLE. Now this morning we are going to proceed in this manner: First we are going to hear from a representative from the inspector general's office. Then we will have a panel of people who have been directly involved in this scam. Then, the third person of note will be Mr. Wachtel, who represents Blue Cross and Blue Shield.

We are going to start off first with the testimony from the Office of the Inspector General of the U.S. Department of Health and Human Services. That representative is Mr. James Cottos, who is regional inspector general for the investigation of the Atlanta region.

Mr. Cottos, I have your statement, and it will be included in the record in its entirety. You can proceed any way you wish, but if you wish, you may just follow your testimony. But we are glad to recognize you at this time. Mr. Cottos.

STATEMENT OF JAMES M. COTTOS, REGIONAL INSPECTOR GENERAL FOR INVESTIGATIONS, ATLANTA FIELD OFFICE, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. COTTOS. Thank you, sir. I appreciate that. I would just like to make a brief opening statement, and then I would rather spend the time that I have answering any particular questions that you and Mr. Shaw have.

I will try to update you on the office's progress in trying to deal with the great magnitude of fraudulent practices we have encountered in the State. As you mentioned in your statement, the Florida population is extremely vulnerable to all of the scams that come about in Medicare because there are so many recipients in this area.

I would like to comment on just a few areas—as Mr. Shaw mentioned, the mobile labs and cholesterol screening. We have several cases open as a result of Mr. Shaw's referral to us where people are lured in by the advertisement of free tests. Basically, when they come in for those free tests, they are told that they have conditions requiring further testing. Of course, this is at no cost to them. Unfortunately, it is not at no cost to Medicare. Most of these tests are unnecessary, and Medicare is often billed for tests that are never performed.

We have two ongoing cases that I would like to mention. One involves cholesterol screening, where the companies are going out to condominiums in senior citizen community centers and just knocking on doors and advertising these tests, saying that they want to give these tests to people. We have one person we have identified who seems to be coordinating these things. He has numerous doctors and labs on his payroll. They are referring people back and forth for costly and unnecessary tests. Also included in that scheme is kickbacks to the doctors and the labs for a number of referrals. We also have an investigation of an ultrasound testing company who is billing $1,200 to $1,800 per patient for tests which are basically unnecessary.

The second area which we have placed almost half of my agents in Florida on in the last year has been the TENS units. Durable medical equipment in the past 5 years has been a major problem in the fraudulent area. Basically, companies use high pressure marketing techniques to get durable medical equipment to recipients. Most of this equipment is equipment that they do not need. All the companies need is the Medicare number and the primary physician, and then they will prepare the false certificates of medical necessity and bill the program.

I mentioned TENS unit; TENS stands for transcutaneous electronic nerve stimulators, and I brought one of those units with us today, if you would like to see one. This is a unit that costs basically $59. Medicare is reimbursing over $500 for these units. This is a regular kit that comes with it.

Chairman Pickle. Can you hold that up a little higher?

Mr. Cottos. These are the leads, the gel to put on the skin. Basically, these units are supposed to help the circulation in your body. For any old person that has arthritis, this is supposed to help the circulation. This is a proven medical device. However, a very small amount of the population can actually benefit from this unit. The problem that we are having is that there is a 30-day trial period involved with this unit. Medicare will pay rental for 30 days. At the end of the 30-day trial period, the person is supposed to go back to their doctor. At that time, the doctor will tell them whether they have benefited from this machine. If they have, then Medicare will purchase it.

What we have found out is that there is no trial period. These units are basically being handed out. Company representatives will go to a community center and just start handing these things out and tell everyone they are free, and that they will fix anything that ails them, basically. And we get charged $600 apiece. The billing in this area has gone up tremendously in the last 2 years. It increased 40 percent nationwide 2 years ago; last year, it increased 220 percent. In the State of Florida, it has increased over 300 percent in the last 2 years. It has been a problem, to say the least.

Recently, we indicted up in Tampa in the middle district of Florida one company, the owner, and three doctors. And the reason we indicted three doctors is that none of these scams, either the testing service scam or the TENS scam, works without a physician. The companies need a physician to sign the prescription, either for the medical equipment or the TENS unit in this particular case. So what we have tried to do is take some actions against those physicians in order to show them that they should not indiscriminately sign the prescriptions.

Chairman Pickle. Mr. Cottos, at this point let me suggest that as we proceed in this hearing, if Mr. Shaw or I either one have any questions, we may interrupt you at this point rather than at the finish.

Mr. Cottos. Absolutely, sir.

Chairman Pickle. Since you have submitted your entire statement for the record——

Mr. Cottos. Yes, sir.

Chairman Pickle [continuing]. We may want to go back and ask specific questions, so we may interrupt you.

Mr. Cottos. That is fine.

Chairman PICKLE. At that point, I want to ask you: You said you did indict three doctors.

Mr. COTTOS. Yes, sir.

Chairman PICKLE. Up in the Tampa area?

Mr. COTTOS. That is correct, sir.

Chairman PICKLE. And when was that?

Mr. COTTOS. That was in the end of February; February 27.

Chairman PICKLE. In connection with this type of violation.

Mr. COTTOS. Yes, sir.

Chairman PICKLE. Alleged violation. Were there any indictments made?

Mr. COTTOS. The indictments were made at the end of February. The owner and the corporation pled guilty last Tuesday. The doctors are scheduled to go on trial next week up in Tampa. Two of the doctors are scheduled to go on trial. One doctor is a fugitive at this time.

Chairman PICKLE. All right. Thank you.

Mr. COTTOS. Yes, sir.

Mr. SHAW. What is the specific charge against the doctors in the indictment?

Mr. COTTOS. The specific charges are filing false claims with the Government, conspiracy to defraud the program, and mail fraud for submitting false statements to the Medicare carrier.

Chairman PICKLE. Were they licensed physicians under the Florida laws?

Mr. COTTOS. Yes, sir, they are, all three of them.

Chairman PICKLE. All right. Thank you.

Mr. COTTOS. One of the methods that we are trying to do to get a better handle on—and again, Mr. Shaw mentioned it in his opening statement—is the ease of obtaining a provider number. In 1985, HCFA was mandated to establish a unique provider information number. Basically, the purpose is so that we can track doctors who either defraud the program, or exercise poor quality of care.

For instance, right now if we sanction a doctor for poor quality of care in Florida, if he were to move to Texas, we have no way of tracking that doctor. He can go right to Texas, apply for a provider number in Texas, and they have the carrier in Texas has no way of knowing that that doctor was sanctioned in Florida.

Chairman PICKLE. And that would work in reverse, if Texas came to Florida.

Mr. COTTOS. That is correct, sir.

Chairman PICKLE. Either way.

Mr. COTTOS. The HCFA was mandated in 1985 to establish this number so that we could follow a physician wherever he went. HFCA has assigned unique identification numbers through a national registry. However, this number addresses physicians only, not other providers as DME suppliers. The other problem that we have is that the Office of Inspector General requested HCFA to establish a standard provider application form. Right now, if I were to submit a claim to Medicare to the carrier, if they did not have any file of me as being a supplier, they would assign me a provider number and send me a check.

What we are looking for is some provider application that would show background, something to be checked so we know who we are paying. Basically, right now, we can be paying anyone.

Chairman PICKLE. Are there any standards at all?

Mr. COTTOS. No, there are not, sir.

Chairman PICKLE. State, local, Federal?

Mr. COTTOS. No. The form, itself, varies from carrier to carrier throughout the country. And what we have asked for is one standard. Some carriers have very stringent requirements and ask a lot of background information; other carriers ask very little information.

Chairman PICKLE. Mr. Shaw.

Mr. SHAW. I was going to ask: Why do you not just use Social Security numbers?

Mr. COTTOS. We have suggested that in the past, and supposedly that is a violation of something else. We have asked about that, and to make that public, and to have everyone know what that physician's Social Security number is a violation of some sort.

Mr. SHAW. I think Chairman Pickle knows something about Social Security. For years, he was chairman of the Social Security Subcommittee so maybe that is something we ought to look into.

Mr. COTTOS. That is a possibility, sir.

Chairman PICKLE. Well, it is not a very involved question with respect to the use of Social Security for identification purposes. But still, there ought to be some way to establish standards, and that ought to be accepted, and it ought to be established, and we will look into that.

Mr. COTTOS. I appreciate that, sir. Basically, that is all of my statement. I would rather spend the time answering specific questions that you have, sir.

[The prepared statement follows:]

STATEMENT BY
JAMES M. COTTOS
REGIONAL INSPECTOR GENERAL FOR INVESTIGATIONS
ATLANTA FIELD OFFICE
OFFICE OF THE INSPECTOR GENERAL

GOOD MORNING. I AM JAMES COTTOS, REGIONAL INSPECTOR GENERAL FOR INVESTIGATIONS OF THE ATLANTA FIELD OFFICE, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES. I AM PLEASED TO HAVE THE OPPORTUNITY TO REPORT ON OUR OFFICE'S PROGRESS IN INVESTIGATING HEALTH CARE FRAUD IN FLORIDA. AMONG OTHER THINGS, MY TESTIMONY WILL DISCUSS THE MAGNITUDE OF FRAUDULENT PRACTICES IN THIS STATE. HOWEVER, AS YOU KNOW, I HAVE TO LIMIT TESTIMONY TO THOSE FACTS WHICH ARE NOT UNDER THE PROTECTION OF THE U.S. DISTRICT COURT, DEPARTMENT OF JUSTICE OR FEDERAL GRAND JURIES, WHICH ARE REVIEWING EVIDENCE IN MANY OF THESE CASES.

BACKGROUND

THE OFFICE OF INSPECTOR GENERAL (OIG) IS RESPONSIBLE FOR OVERSEEING ABOUT 300 PROGRAMS FOR OUR DEPARTMENT. WE FOCUS OUR EFFORTS AND RESOURCES ON THE MEDICARE AND SOCIAL SECURITY PROGRAMS. THESE PROGRAMS ACCOUNT FOR OVER 80 PERCENT OF THE DEPARTMENT'S BUDGET. THE SHEER MAGNITUDE OF THESE PROGRAMS MAKES THEM VULNERABLE TO FRAUD, WASTE, AND ABUSE.

FUNDING SPENT ON THE OFFICE OF INSPECTOR GENERAL IS A SOUND INVESTMENT. IN FISCAL YEAR 1989, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, WHICH ADMINISTERS THE MEDICARE PROGRAM, SPENT APPROXIMATELY $100 BILLION FOR THE HEALTH CARE OF MORE THAN 33 MILLION BENEFICIARIES. DURING THAT TIME, EACH DOLLAR INVESTED IN OUR OFFICE RESULTED IN SAVINGS OF OVER $66. WE ARE PROUD OF OUR STATISTICAL ACCOMPLISHMENTS AND THE SUCCESSES WE HAVE HAD IN ENSURING THAT THOSE INDIVIDUALS WHO DEFRAUD THE DEPARTMENT'S PROGRAMS ARE HELD ACCOUNTABLE FOR THEIR ACTIONS.

THUS FAR IN FISCAL YEAR 1990, $2.1 BILLION IN SETTLEMENTS, FINES, RESTITUTIONS, RECEIVABLES AND SAVINGS HAVE RESULTED FROM OIG ACTIVITIES AND IMPLEMENTATION OF OIG RECOMMENDATIONS NATIONWIDE. THE INVESTIGATIVE STAFFS' EFFORTS HAVE RESULTED IN ABOUT 1200 SUCCESSFUL JUDICIAL PROSECUTIONS IMPOSED AGAINST THOSE FOUND GUILTY OF DEFRAUDING THE PROGRAMS OR BENEFICIARIES OF THE DEPARTMENT. AMONG THESE, WE HAVE COMPLETED ABOUT 800 SUCCESSFUL ACTIONS AGAINST HEALTH CARE PROVIDERS WHO VIOLATED PROVISIONS OF THE MEDICARE AND MEDICAID PROGRAMS. THESE 800 ACTIONS INCLUDE CIVIL MONETARY PENALTIES AND OTHER ADMINISTRATIVE SANCTIONS SUCH AS DEBARMENTS, SUSPENSIONS AND EXCLUSIONS FROM THE MEDICARE OR MEDICAID PROGRAMS.

INVESTIGATIONS OF HEALTH CARE FRAUD IN FLORIDA

AS YOU KNOW, FLORIDA'S LARGE ELDERLY POPULATION IS PARTICULARLY VULNERABLE TO FRAUDULENT HEALTH CARE SCHEMES AND TACTICS. THIS HAS KEPT OUR AGENTS BUSY IN THIS STATE. OVER THE LAST FOUR YEARS, AS A RESULT OF CASES WE'VE INVESTIGATED IN FLORIDA, WE HAVE RECOUPED APPROXIMATELY $934,000 IN CRIMINAL RECOVERIES, $210,000 IN CRIMINAL RESTITUTIONS, AND $426,000 IN CRIMINAL FINES. WE ALSO HAVE LEVIED CIVIL MONETARY PENALTIES OF ABOUT $6,723,000. WE HAVE ABOUT 40 HEALTH CARE CASES UNDER ACTIVE INVESTIGATION IN FLORIDA.

THERE ARE CERTAIN PATTERNS WHICH HAVE MANIFESTED THEMSELVES OVER THE YEARS. THE MOST PREVALENT FRAUDS IN FLORIDA INVOLVE:

- UNAUTHORIZED OR EXCESSIVE TESTS;
- DURABLE MEDICAL EQUIPMENT SUPPLIERS;
- CLAIMS FOR SERVICES THAT ARE EITHER NOT BILLED OR BILLED INCORRECTLY ("RECOVERY BILLING"); AND
- CONTRACTOR FRAUD.

LET ME BRIEFLY DETAIL SOME OF THE FRAUD SCHEMES WE HAVE IDENTIFIED THAT ARE PREVALENT.

1. UNAUTHORIZED OR EXCESSIVE TESTS

WE HAVE BEEN INVESTIGATING POSSIBLE MEDICARE FRAUD ON THE PART OF

TESTING SERVICES. ALONG WITH YOUR SUBCOMMITTEE, WE HAVE CONCERNS ABOUT THE TESTING PROCEDURES AND THE PRICES CHARGED FOR THEM.

IN SOME INSTANCES, MEDICARE BENEFICIARIES ARE LURED IN UNDER THE PRETEXT OF A FREE CHOLESTEROL OR OTHER MEDICAL TEST. AFTER THE FREE CHECKS, THEY ARE TOLD THAT THEY HAVE CONDITIONS REQUIRING FURTHER TESTING -- AT NO COST TO THEM IF THEY PROVIDE A MEDICARE OR OTHER INSURANCE NUMBER. MANY ARE REFERRED TO MOBILE LABS FOR FURTHER TESTING, WHERE THEY ARE PRESSURED INTO TAKING COSTLY, UNNECESSARY TESTS, SUCH AS VASCULAR AND X-RAY EXAMINATIONS. EVENTUALLY, MEDICARE AND PRIVATE INSURANCE COMPANIES ARE BILLED HUNDREDS OF THOUSANDS OF DOLLARS IN CHARGES FOR THESE ADDITIONAL EXAMINATIONS. OFTEN, THIS BILLING IS FOR TESTS WHICH WERE NOT ACTUALLY PERFORMED. LET ME PROVIDE YOU WITH SOME EXAMPLES.

- AS YOU MAY KNOW, WE HAVE AN ONGOING CASE WHERE A SOUTH FLORIDA CLINIC HAS SET UP CHOLESTEROL SCREENINGS FOR ELDERLY SOUTH FLORIDA RESIDENTS IN CONDOMINIUMS AND COMMUNITY CENTERS. IT IS RUN BY A FORMER CHIROPRACTOR WHO IS BARRED FROM THE MEDICARE SYSTEM. THIS PROVIDER ALLEGEDLY ORGANIZED A NETWORK OF DOCTORS AND LABS TO CARRY OUT COSTLY MEDICAL TESTS. HE THEN ACCEPTED KICKBACKS BASED ON THE NUMBER OF PATIENTS REFERRED FOR TESTING.

- WE HAVE CONCERNS ABOUT ONE COMPANY'S ULTRA SOUND TESTING PROCEDURES. WE BELIEVE THAT PHYSICIANS ARE HIRED BY THIS COMPANY TO AUTHORIZE AND CONDUCT EXPENSIVE TESTS. THIS COMPANY IS BILLING MEDICARE AT A RATE OF $1200 - $1800 PER PATIENT FOR UNNECESSARY TESTS, AND THE REFERRING PHYSICIANS MAY BE RECEIVING KICKBACKS. THIS INVESTIGATION IS CONTINUING.

WE ARE IN THE INITIAL STAGES OF OTHER INVESTIGATIONS WHERE UNAUTHORIZED OR EXCESSIVE TESTS MAY HAVE BEEN PERFORMED. IN ADDITION TO CONDUCTING INVESTIGATIONS SUCH AS THESE, THE OIG IS ALSO CONDUCTING SEVERAL STUDIES CONCERNING THE PRACTICES OF CHOLESTEROL TESTING AND MOBILE LABS. I WILL BE DISCUSSING THESE IN DETAIL LATER IN MY TESTIMONY.

2. DURABLE MEDICAL EQUIPMENT SUPPLIERS

ANOTHER AREA I WOULD LIKE TO DISCUSS IS DURABLE MEDICAL EQUIPMENT. AS INVESTIGATORS FOR FRAUD AND ABUSE IN HEALTH CARE, THE OIG IS SEEING A NATIONWIDE PROLIFERATION OF PROBLEMS WITH DME SUPPLIERS. AS WITH TESTING SERVICES, WE HAVE FOUND THAT DME COMPANIES OFTEN USE INTENSE, HIGH PRESSURE MARKETING TECHNIQUES TO GET BENEFICIARIES TO ORDER EQUIPMENT THEY DON'T REALLY NEED. THROUGH TELEVISION SOLICITATIONS, ROUTINE SCREENINGS, OR MASS MAILINGS, BENEFICIARIES ARE TOLD THAT EQUIPMENT CAN BE SUPPLIED IN THEIR HOMES AT NO COST. THE COMPANIES OBTAIN THE BENEFICIARY'S PRIMARY PHYSICIAN'S NAME AND HEALTH INSURANCE CLAIM NUMBERS. THE COMPANIES THEN PREPARE FALSE AUTHORIZATION DOCUMENTS, KNOWN AS CERTIFICATES OF MEDICAL NECESSITY, NEEDED TO BILL THE EQUIPMENT TO MEDICARE. THESE DOCUMENTS OFTEN LIST DME WHICH THE BENEFICIARY HAS NOT REQUESTED, AND SHOW FALSE DIAGNOSES. THE PHYSICIANS ARE THEN PRESSURED TO SIGN THE FRAUDULENT AUTHORIZATIONS, SOMETIMES AFTER BEING THREATENED WITH PATIENT LOSS OR LAWSUITS.

MANY OF OUR DME INVESTIGATIONS INVOLVE TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICES. THESE ARE LOW-VOLTAGE ELECTRICAL IMPULSE GENERATORS DESIGNED TO RELIEVE PAIN WITHOUT THE USE OF NARCOTICS. BECAUSE THEY MAY POSE A DANGER TO PERSONS WITH CARDIAC PROBLEMS OR PACEMAKERS, IT IS IMPERATIVE THAT THEIR USE BE CLOSELY MONITORED. LET ME PROVIDE SOME EXAMPLES OF OUR WORK IN THIS AREA.

- WE HAVE ONE CASE IN FLORIDA WHERE A DME SUPPLIER EMPLOYED CONTRACT SALESPERSONS TO PROCURE TENS BUSINESS

ON A COMMISSION BASIS. MANY OF THESE SALESPERSONS DRESSED IN MEDICAL ATTIRE WHEN VISITING CUSTOMERS, AND FALSELY STATED THAT THEY WERE FROM MEDICARE OR MEDICAID. THESE SALESPERSONS WOULD TELL CUSTOMERS THAT TENS UNITS COULD BE SUPPLIED AT NO COST. THE SALESPERSONS WOULD THEN PREPARE FALSE PRESCRIPTIONS NEEDED TO BILL MEDICARE AND PAY KICKBACKS TO PHYSICIANS TO AUTHORIZE THEM. THIS INVESTIGATION IS ONGOING.

- IN ANOTHER CASE, A DME SUPPLIER, ITS PRESIDENT, AND TWO MEDICAL DOCTORS HAVE BEEN CHARGED WITH SUBMITTING FALSE MEDICARE AND PRIVATE INSURER CLAIMS FOR TENS UNITS AND OTHER EQUIPMENT. ONE DOCTOR WAS CHARGED WITH PRESCRIBING TENS UNITS AND SIGNING BLANK FORMS USED BY THE SUPPLIER IN BILLING MEDICARE FOR TENS UNITS. ANOTHER DOCTOR IS CHARGED WITH PERJURY.

AS A RESULT OF OUR WORK IN THIS AREA, THE FLORIDA CARRIER HAS MODIFIED THE CERTIFICATE OF MEDICAL NECESSITY TO REQUIRE ADDITIONAL INFORMATION FROM THE BENEFICIARY'S PHYSICIAN. THIS HAS CONSIDERABLY REDUCED THE NUMBER OF FRAUDULENT CLAIMS IN THIS AREA.

ANOTHER FRAUDULENT PRACTICE USED BY DISHONEST DME COMPANIES IS LOCALITY BILLING. UNETHICAL COMPANIES HAVE DEVELOPED SCHEMES TO MAKE IT APPEAR THAT THEY ARE LOCATED IN, AND MAKE THEIR SALES FROM, LOCALITIES THAT PAY A HIGHER REIMBURSEMENT RATE. THIS IS BEING DONE TO EVADE MEDICARE REQUIREMENTS LIMITING DME REIMBURSEMENT TO THE LOWEST LEVEL AVAILABLE IN A LOCALITY. EXAMPLES OF THIS KIND OF INVESTIGATION CAN BEST BE ILLUSTRATED BY THE FOLLOWING CASES.

- A RECENT CASE INVOLVED A DME SUPPLIER IN TEXAS THAT WAS BILLING CARRIERS IN FLORIDA AND NORTH DAKOTA IN ORDER TO GAIN MAXIMUM REIMBURSEMENT FOR THEIR PRODUCTS. WASHINGTON GROUP INC. (WGI) AND ITS OWNER WERE CHARGED WITH FELONY MEDICARE FRAUD AND SUBSEQUENTLY PLED GUILTY. WGI WAS ORDERED TO RELINQUISH $102,000 IN MEDICARE PAYMENTS HELD IN ESCROW, WAIVE ALL RIGHTS TO APPEAL THE DENIAL OF $800,000 IN MEDICARE CLAIMS, AND PAY A CIVIL MONETARY PENALTY OF $25,000. WGI WAS ALSO EXCLUDED FROM THE MEDICARE AND MEDICAID PROGRAMS FOR SEVEN YEARS. RECENTLY THE OWNER WAS FINED AN ADDITIONAL $25,000 AND WAS SENTENCED TO THREE YEARS PROBATION.

  THE NATIONWIDE INVESTIGATION REVEALED THAT WGI OPERATED A SCHEME TO PROVIDE URINARY CATHETERS TO NURSING HOMES AS "FREE" SAMPLES, AND THEN BILLED MEDICARE FOR THE UNNEEDED, UNWANTED, AND OFTEN UNUSABLE SUPPLIES. THE BILLS OFTEN MISSTATED WHERE THE SALE WAS ACTUALLY MADE. SHIPMENTS AND BILLINGS CONTINUED, EVEN AFTER ORDERS WERE CANCELLED, SUPPLIES WERE RETURNED, OR -- IN A FEW INSTANCES -- THE BENEFICIARIES HAD DIED.

- WE HAVE AN ONGOING CASE INVOLVING A DME SUPPLIER IN PENNSYLVANIA THAT HAS SUBSIDIARIES IN FLORIDA AND OTHER STATES. THE SUBSIDIARIES ARE ALLEGEDLY BILLING PENNSYLVANIA BLUE SHIELD TO OBTAIN MAXIMUM REIMBURSEMENT FOR THEIR PRODUCTS. WE ARE IN THE PROCESS OF DETERMINING THE EXTENT TO WHICH THIS FRAUDULENT ACTIVITY IS OCCURRING.

- WE ARE ALSO INVESTIGATING A FLORIDA BILLING SERVICE THAT MAY HAVE PREPARED BILLINGS FOR ABOUT 15 PENNSYLVANIA DME AND AMBULANCE COMPANIES. THESE COMPANIES ARE, IN TURN, USING THIS BILLING SERVICE TO OBTAIN BENEFICIARY INFORMATION FOR SOLICITATION PURPOSES. WE ARE IN THE PROCESS OF OBTAINING ADDITIONAL INFORMATION ABOUT THESE BILLINGS.

3. CLAIMS FOR SERVICES THAT ARE EITHER NOT BILLED OR BILLED INCORRECTLY ("RECOVERY BILLING")

IN RECOVERY BILLING, COMPANIES REVIEW PROVIDER RECORDS OVER A SPECIFIED PERIOD AND IDENTIFY "UNBILLED SERVICES". THESE UNBILLED SERVICES ARE SUBMITTED TO THIRD PARTY PAYERS FOR REIMBURSEMENT. TEACHING PROVIDERS AND BILLING SERVICES HOW TO RECOVER BILLINGS BY DEALING WITH THE MEDICARE CODING SYSTEM HAS LED TO A BOOMING BUSINESS FOR SOME MEDICAL BUSINESSES AND CONSULTANTS.

IN RECENT CONGRESSIONAL TESTIMONY, WE DISCUSSED TECHNIQUES FOR ILLEGALLY MANIPULATING RECOVERY BILLINGS. IN FILLING OUT AN INSURANCE FORM, FOR EXAMPLE, A BILLING SERVICE MIGHT FALSELY CODE THE REMOVAL OF A THREE-MILLIMETER MOLE AS THE REMOVAL OF A TWO-CENTIMETER MOLE. THIS SIMPLE "UPCODING" PROCEDURE EARNS THE CLIENT $190 MORE FROM A HEALTH INSURER. IN ANOTHER PROCEDURE KNOWN AS "FRAGMENTATION", A BILLING SERVICE MIGHT CODE A HYSTERECTOMY AS A NUMBER OF SEPARATE PROCEDURES -- FOR EXAMPLE, EXPLORATION OF THE ABDOMEN, REMOVAL OF OVARIES AND TUBES, AND REMOVAL OF SCAR TISSUE. THIS TECHNIQUE CAN BRING IN THOUSANDS OF DOLLARS. A THIRD TECHNIQUE IS KNOWN AS "EXPLODING" A TEST. A CONTRACTOR MIGHT SUBMIT ITEMIZED BILLINGS FOR A SERIES OF TESTS THAT WERE ALL DONE ON A SINGLE SAMPLE OF BLOOD, THEREBY TURNING A $25 ANALYSIS INTO ONE THAT COSTS $150.

MANY FRAUDULENT BILLINGS INVOLVE THE ARTFUL MANIPULATION OF CURRENT PROCEDURAL TERMINOLOGY CODES, OR CPT, ESTABLISHED IN 1966 BY THE AMERICAN MEDICAL ASSOCIATION (AMA) TO DISTINGUISH MORE THAN 7,000 DIFFERENT MEDICAL PROCEDURES. LAST YEAR, MEDICARE AND PRIVATE INSURANCE COMPANIES BEGAN REQUIRING DOCTORS TO USE CPT CODES ON THEIR BILLS. THE SYSTEM IS COMPLICATED.

LET ME GIVE YOU AN EXAMPLE OF A MAJOR CASE WE HAVE INVESTIGATED IN THIS AREA:

- A FEDERAL GRAND JURY IN MASSACHUSETTS RECENTLY INDICTED INCOM-RX SYSTEMS, LIMITED PARTNERSHIP, AND INCOM-RX SYSTEMS, INC. (GENERAL PARTNER) IN CONNECTION WITH MORE THAN 25,000 BILLINGS PREPARED AND SUBMITTED ON BEHALF OF A LOCAL EYE CLINIC. ORIGINALLY INDICTED ON CHARGES OF DEFRAUDING THE MEDICARE PROGRAM OF MORE THAN $400,000, A 24 COUNT SUPERCEDING INDICTMENT CITED CHARGES OF MAIL FRAUD AND PREPARING AND SUBMITTING FALSE CLAIMS. THE INVESTIGATION REVEALED THAT INCOM-RX FURNISHED RECOVERY BILLING SERVICES -- FOR AS MUCH AS A 50% COMMISSION -- TO OVER 25 PROVIDERS AND SUBMITTED CLAIMS TO MANY DIFFERENT THIRD PARTY PAYERS IN FLORIDA AND OTHER STATES.

4. CONTRACTOR FRAUD

IN ADDITION TO THE INVESTIGATIONS OF HEALTH CARE PROVIDERS, WE HAVE BEEN INVOLVED IN INVESTIGATION OF MEDICARE CONTRACTORS, INCLUDING THE FLORIDA PEER REVIEW ORGANIZATION (PRO).

IN AN EFFORT TO CURB RISING HOSPITAL COSTS WHILE ENSURING THAT MEDICARE BENEFICIARIES RECEIVE HIGH-QUALITY MEDICAL CARE, THE CONGRESS ESTABLISHED THE PRO PROGRAM THROUGH THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982. PROS, WHICH BEGAN OPERATING IN 1984, REVIEW HOSPITAL RECORDS FOR ABOUT ONE-FOURTH OF ALL MEDICARE PATIENT ADMISSIONS. MEDICALLY TRAINED PERSONNEL, USUALLY REGISTERED NURSES OR ACCREDITED MEDICAL RECORDS TECHNICIANS, SCREEN CASES FOR INSTANCES OF UNNECESSARY OR POOR QUALITY CARE. HOWEVER, WE HAVE UNCOVERED PROBLEMS WITH SOME OF THESE MEDICARE CONTRACTORS.

- FOR EXAMPLE, IN FLORIDA, THE FLORIDA PRO AND ITS DATA MANAGER WERE INDICTED ON CHARGES OF CONSPIRACY AND MAKING FALSE STATEMENTS. THE INVESTIGATION REVEALED THAT ABOUT 250 PAYMENT DECISIONS, MADE DURING THE

> REVIEW AND SCREENING PROCESSES, WERE CHANGED WITHOUT THE REQUIRED MEDICAL REVIEW. AS A DIRECT RESULT OF THIS INDICTMENT, HCFA ANALYZED PAYMENT VOUCHERS AND FOUND THAT THE PRO HAD BEEN OVERPAID $1.9 MILLION. HCFA HAS INITIATED ACTION TO RECOVER THE MONIES.

FRAUD INVOLVING PROS IS PARTICULARLY SERIOUS, BECAUSE THEY CARRY OUT GREATLY NEEDED FUNCTIONS TO INSURE THE ACCURACY OF MEDICARE PAYMENTS. GIVEN THE CONTINUING RISE IN THE NUMBER AND COST OF MEDICARE CLAIMS, IT IS IMPERATIVE THAT PROS ACCURATELY SCREEN CASES FOR INSTANCES OF UNNECESSARY OR POOR QUALITY CARE.

OTHER OIG ACTIVITIES

1. TESTING PROCEDURES

FIRST, I WOULD BE PLEASED TO DISCUSS THREE OIG STUDIES CONCERNING TESTING PROCEDURES. WITH YOUR PERMISSION, WE WOULD LIKE TO SUBMIT A COPY OF OUR REPORT ENTITLED "PUBLIC CHOLESTEROL SCREENING" WHICH WAS ISSUED IN MAY 1990. IN CONDUCTING THIS STUDY OIG STAFF PARTICIPATED IN 71 SCREENINGS THROUGHOUT THE COUNTRY AND INTERVIEWED FEDERAL AND STATE OFFICIALS AND EXPERTS IN THE FIELD. WE FOUND THAT PUBLIC CHOLESTEROL SCREENING IN MANY AREAS IS BOTH PREVALENT AND GROWING; PROVIDERS OF ALL KINDS ARE CONDUCTING SCREENINGS. THE RESULTS OF THE FIELD SURVEY SHOW THAT THE ACCURACY AND USEFULNESS OF PUBLIC CHOLESTEROL SCREENING ARE COMPROMISED BY POOR QUALITY ASSURANCE, INADEQUATE ON-SITE COUNSELING, AND LACK OF A REFERRAL TO A PHYSICIAN WHEN APPROPRIATE. WE ALSO FOUND THAT STATE AND FEDERAL REGULATION OF PUBLIC CHOLESTEROL SCREENING IS MINIMAL.

WE WOULD ALSO LIKE TO SUBMIT A COPY OF OUR REPORT ENTITLED "MOBILE HEALTH SERVICES" WHICH WAS JUST RELEASED. IN CONDUCTING THIS STUDY OIG STAFF HELD TELEPHONE DISCUSSIONS WITH 241 PERSONS AND INTERVIEWED FEDERAL AND STATE OFFICIALS AND EXPERTS IN THE FIELD. WE FOUND THAT PROVIDERS DELIVER ALL KINDS OF SERVICES IN MOBILE, NON-PERMANENT SETTINGS; THE PREVALENCE OF MOBILE HEALTH SERVICES IS DIFFICULT TO DETERMINE. THE RESULTS OF OUR WORK SHOW THAT REGULATION OF MOBILE HEALTH SERVICES VARIES WIDELY FOR SOME SERVICES AND IS NON EXISTENT FOR OTHERS. RESPONDENTS TO OUR SURVEY AGREED THAT MOBILE HEALTH SERVICES CAN IMPROVE ACCESS TO CARE. HOWEVER, THEY RAISE QUESTIONS RELATED TO THE PREVALENCE, QUALITY, COST, AND DEGREE OF REGULATION OF THESE SERVICES.

IN ADDITION TO THESE REPORTS, WE ARE NOW DRAFTING ONE OTHER REPORT RESULTING FROM A REQUEST THAT WE EXAMINE MOBILE HEALTH SERVICES. THIS REPORT DESCRIBES A FEW INNOVATIVE HEALTH CARE PROVIDERS THAT ARE SERVING PEOPLE, INCLUDING MEDICALLY UNDERSERVED OR UNINSURED GROUPS, IN THEIR HOMES OR IN PUBLIC SETTINGS. THESE TYPES OF SERVICES, IN ADDITION TO PROVIDING ACCESS TO HEALTH CARE IN INNOVATIVE WAYS, MAY LEAD TO HEALTH CARE COST SAVINGS BY TAKING A PREVENTIVE APPROACH. WE ANTICIPATE RELEASING THIS REPORT SHORTLY.

2. DURABLE MEDICAL EQUIPMENT SUPPLIERS

SECOND, IN RESPONSE TO THE GROWING CRITICISM REGARDING THE DISPENSING OF DME SUPPLIES, WE DEVELOPED A NOTICE WITH THE ASSISTANCE OF HCFA ALERTING MEDICARE BENEFICIARIES IN CERTAIN STATES TO FRAUDULENT PRACTICES REGARDING DME COMPANIES. IT DISCUSSES HOW BENEFICIARIES CAN AVOID THE PURCHASE OF UNNECESSARY AND UNWANTED DME SERVICES, SUPPLIES, AND EQUIPMENT.

WE HAVE ALSO SENT NUMEROUS INTERNAL FRAUD ALERTS TO HCFA CARRIERS AND INTERMEDIARIES CONCERNING VARIOUS DME AREAS, SUCH AS:

- o THE LARGE NUMBER OF TENS MAINTENANCE UNITS THAT ARE BEING BILLED BY DME COMPANIES;
- o MISUSE OF PHYSICIAN AUTHORIZATION FORMS TO OBTAIN

PAYMENT FOR TENS; AND,

- LACK OF STANDARDS FOR ACCEPTANCE OF DURABLE MEDICAL EQUIPMENT AUTHORIZATION FORMS.

WE ARE ALSO ISSUING AN INTERNAL FRAUD ALERT TO OUR FIELD OFFICES BASED ON A CURRENT INVESTIGATION IN FLORIDA. THIS INVESTIGATION HAS REVEALED THAT A SUPPLIER OF FOOT SPLINTS AND SUPPLIES, KNOWN AS ORTHOTICS, IS OBTAINING MEDICARE PAYMENTS FOR DEVICES THAT WERE IMPROPERLY AUTHORIZED BY THE PATIENT'S PHYSICIAN AND WERE NOT PROVIDED AS CLAIMED. WE ARE ALERTING CARRIERS AND INTERMEDIARIES TO THIS TYPE OF ACTIVITY, AND ENCOURAGING THEM TO DETERMINE WHETHER PHYSICIAN AUTHORIZATIONS ARE PERFORMED BEFORE DEVICES ARE PROVIDED TO PATIENTS.

3. PROVIDER NUMBERS

THIRD, MANY OF THE FRAUDULENT SCHEMES DISCUSSED ABOVE INVOLVE THE MISUSE OF EASILY OBTAINED PROVIDER NUMBERS. THESE NUMBERS ARE USED TO IDENTIFY SPECIFIC PROVIDERS FOR BILLING PURPOSES. UNFORTUNATELY, YOU CAN NOW GET A PROVIDER NUMBER AND SUBMIT BILLS, REGARDLESS OF WHETHER OR NOT YOU ARE QUALIFIED TO DO SO. TO CORRECT THIS PROBLEM, HCFA WAS MANDATED BY LAW TO ESTABLISH A UNIQUE IDENTIFIER FOR EACH PHYSICIAN WHO PROVIDES SERVICES FOR WHICH PAYMENT IS MADE UNDER MEDICARE. HCFA HAS ASSIGNED UNIQUE PHYSICIAN IDENTIFICATION NUMBER (UPIN) THROUGH A NATIONAL REGISTRY. HOWEVER, THE UPIN ADDRESSES PHYSICIANS ONLY, NOT OTHER PROVIDERS SUCH AS DME SUPPLIERS.

WE HAVE CONSISTENTLY DOCUMENTED PROBLEMS IN THIS AREA. FOR EXAMPLE, OUR INVESTIGATIONS REVEALED THAT THE PRESENT SYSTEM OF ISSUING PROVIDER NUMBERS VARIES WIDELY FROM CARRIER TO CARRIER, WITH THE MAJORITY OF CARRIERS REQUIRING VERY LITTLE DATA FROM THE PROVIDER. SOME YEARS AGO, WE SENT HCFA A MANAGEMENT IMPLICATION REPORT ALERTING THEM TO SIGNIFICANT PROBLEMS CAUSED BY THIS LACK OF UNIFORM REQUIREMENTS IN THE ASSIGNMENT OF PROVIDER NUMBERS. WE ALSO WARNED THEM THAT MEDICARE IS VULNERABLE TO PROVIDERS WHO HAVE BEEN SANCTIONED FROM THE PROGRAM AND RELOCATE TO OTHER STATES.

AS A FIRST STEP, WE REQUESTED THAT HCFA DIRECT THE MEDICARE CARRIERS TO USE A STANDARD, COMPREHENSIVE PROVIDER NUMBER APPLICATION FORM. HCFA PROPOSED TO STUDY THE FEASIBILITY OF MONITORING, EVALUATING AND UPDATING THE DATA REPORTED BY THE PROVIDERS IN THEIR APPLICATIONS.

CURRENTLY, WE ARE EXAMINING THE PROCESS WHEREBY MEDICARE CARRIERS ISSUE A PROVIDER NUMBER UNDER PART B OF MEDICARE. WE WILL DETERMINE WHAT VULNERABILITIES EXIST OR PROBLEMS OCCUR AS A RESULT OF PROVIDERS HAVING MORE THAN ONE NUMBER AT A TIME OR AT DIFFERENT TIMES. IN ADDITION, WE WILL DETERMINE WHAT DOCUMENTATION AND PRE-AUTHORIZATION IS NEEDED TO PROTECT THE FINANCIAL INTEGRITY OF THE MEDICARE PROGRAM.

4. CONTRACTOR RESPONSIBILITIES

FINALLY, OUR FRAUD ALERTS OFTEN NOTIFY THE MEDICARE CARRIERS OF THE NEED TO DEVELOP SYSTEMS TO PROTECT MEDICARE FROM THE UNNECESSARY UTILIZATION OF SERVICES FURNISHED BY PROVIDERS AND SUPPLIERS. WORKING WITH HCFA AND THEIR CONTRACTORS ALLOWS US TO INTRODUCE NEW TECHNIQUES IN THEIR PRE AND POST PAYMENT PROCESSES TO BETTER IDENTIFY BAD CLAIMS. WE BELIEVE THAT THERE IS STILL ROOM FOR SIGNIFICANT IMPROVEMENT IN CARRIERS' CLAIMS PROCESSING AND PAYMENT SAFEGUARD FUNCTIONS.

THIS CONCLUDES MY TESTIMONY. I AM AVAILABLE TO ANSWER YOUR QUESTIONS.

Chairman **Pickle**. Well, I do have several questions, and I am going to try to go through some of these. Mr. Shaw and I both will be asking questions. I wish now I would have had you read the whole statement so we could have a better flavor of this entire thing. But let me go back to ask you some specific questions. You said that there was a lot of fraud with respect to the use of the durable equipment.

Mr. **Cottos**. Yes, sir.

Chairman **Pickle**. DMEs. What type of equipment are they trying to sell or prescribe?

Mr. **Cottos**. Well, our major problems we have had are in seat-lift chairs and the TENS units. Those are basically the two largest, and the oxygen area. We have also had a problem with oxygen.

Chairman **Pickle**. All right. Seat lift chair, and what else?

Mr. **Cottos**. Seat lift chairs, the transcutaneous electronic nerve stimulators, and also in the oxygen area.

Chairman **Pickle**. All right. Do we have any instances where there has been abuse of this, or is it just sort of a fractious little plaything?

Mr. **Cottos**. Well, one of the major concerns that we have is that these things are handed out. For instance, we do not know what effect that is going to have if someone has a pacemaker, if you hook that up to your body. And when they are handing these things out indiscriminately, they are not even asking anyone. They are supposed to do a complete physical. It is supposed to be prescribed by the regular treating physician. But if you just walk up to a house and hand it to someone, you have no idea.

Chairman **Pickle**. Well, if the so-called physician says to a person to be screened, "Here, let me have your hand. I want to put this on you," they will comply and they will do it.

Mr. **Cottos**. That is correct.

Chairman **Pickle**. There is no testing about their own condition or anything else.

Mr. **Cottos**. What we have found, sir, is most of the physicians who sign the prescriptions are not the treating physician. They are simply a physician that goes along, that works basically for the durable medical equipment company. And instead of doing a physical, all they do is take the blood pressure and pulse and say, "Yes, you can benefit from this machine." That is what we have found in our investigations.

Chairman **Pickle**. All right. It says here that you have some people who came over from, you said, a DME supplier in Texas that was billing carriers in Florida and North Dakota in order to gain maximum reimbursement for their products. Can you tell me what supplier was that in Texas?

Mr. **Cottos**. That was WGI out of Dallas, Tex. They pled guilty about 5 months ago.

Chairman **Pickle**. That was the WGI.

Mr. **Cottos**. That is the WGI investigation. Yes, sir.

Chairman **Pickle**. All right. All right, thank you. How long has this investigation been going on here in Florida?

Mr. **Cottos**. Which in particular?

Chairman **Pickle**. This particular one with respect to the TENS and the screening of cholesterol.

Mr. COTTOS. The cholesterol screening has been going on for about 6 or 7 months. We have known about it. Mr. Shaw's information expanded what we already knew, and we expanded that investigation. Right now, we probably have 7 cases open on testing services specifically, and 15 cases open in Florida right now on TENS companies.

Chairman PICKLE. All right. If you had 7 to 15 cases, and that was started in January, has there been any indictment?

Mr. COTTOS. Not in south Florida at this time. No, sir. Those investigations are continuing now.

Chairman PICKLE. But that has been going on now 8 months.

Mr. COTTOS. Yes, sir.

Chairman PICKLE. And no indictment other than just investigations.

Mr. COTTOS. That is correct, sir.

Chairman PICKLE. Is that normal? Is that regular?

Mr. COTTOS. Yes, sir, it is.

Chairman PICKLE. Do the judicial proceedings go that slowly?

Mr. COTTOS. Yes, sir, they do. For us to get allegations and go out and firm up those allegations, and then get documents from the carrier, from Blue Cross—and right now, we have had a problem getting records. When we request the records, we have a problem in getting those records.

Chairman PICKLE. Well, I should ask Mr. Shaw, but I assumed that there was some person or persons who organized this alleged scam. Is that correct?

Mr. COTTOS. That is correct, sir.

Chairman PICKLE. Has that person or persons been identified?

Mr. COTTOS. They have been identified.

Chairman PICKLE. And yet there has been no——

Mr. COTTOS. No. We have not assembled enough proof to present to a grand jury for indictment at this time. We are still investigating at this time.

Chairman PICKLE. Now, we are going to hear witnesses here this morning and officially put that on the record. And yet you say you have no proof.

Mr. COTTOS. No. I did not say we did not have proof, Mr. Pickle. What I said was that we have to have enough proof to present to a grand jury for an indictment. One of the criteria that we have to deal with is the U.S. attorney's office in Miami. Any investigations that we conduct in south Florida have to be presented to the U.S. attorney's office in Miami for them to coordinate with us and to present that investigation to a grand jury.

Chairman PICKLE. Well, it is not proper for us to criticize the judicial system because everybody has got the right to have a court trial. But it would seem to me that this is going on in an inordinately slow manner, and if this is true in cases where on the record it looks obvious, then surely the same type of thing is taking place all over the United States. If we do not put a stop to it and put some of these crooks behind bars, then that injustice is perpetrated, and more than that, it just continues.

Mr. COTTOS. That is correct, sir.

Chairman PICKLE. The Medicare program is literally milked out of billions of dollars.

Mr. COTTOS. That is correct, sir.

Chairman PICKLE. Well, I want to go back. Mr. Shaw, let me yield to you for any questions you might have of Mr. Cottos.

Mr. SHAW. Thank you. Mr. Cottos, you mentioned that you are having trouble getting records from Blue Cross and Blue Shield. What is the problem with getting those records? Are they being cooperative, not cooperative? Is it a problem of retrieval?

Mr. COTTOS. Well, I think basically, they are being cooperative. I think there has been a problem with retrieval. What we have been told is that we are not the first priority for the carrier. The carrier is reimbursed by the Health Care Financing Administration, and the fraud and referral work is not their first priority. They basically are reimbursed for the number of claims processed, so referral of fraud is not their primary responsibility or their primary concern. Accordingly, we have been set back. When we ask for records, we do not get the records as quickly as we like. We sometimes wait 3, 4, 5 months to get records that we request from the carrier.

Mr. SHAW. All right. Let us back up for just a moment in the whole process. When a claim is filed, it is filed with Blue Cross and Blue Shield.

Mr. COTTOS. That is correct, sir.

Mr. SHAW. Blue Cross and Blue Shield is the only agency that tests the authenticity of the tests, the need for the tests, and the advisability of payment. Is that not correct?

Mr. COTTOS. That is correct.

Mr. SHAW. So if there was fraud perpetrated, it was perpetrated upon Blue Cross and Blue Shield, who assumedly unknowingly paid out a fraudulent claim, and I have no reason to believe it otherwise. Is that correct?

Mr. COTTOS. That is correct, sir.

Mr. SHAW. So then what you are doing is investigating errors in judgment of Blue Cross and Blue Shield for which they say that is not one of their priorities.

Mr. COTTOS. Well, I think that basically, our job is to investigate to find out whether those claims are fraudulent or not. I think on Blue Cross' behalf, they don't have all the information when they're processing those claims that we might have in investigating them.

Mr. SHAW. Believe me, I can tell you as a former lawyer, there is nothing like hindsight to make a witness look foolish. But what we are talking about is such a large portion of the Federal budget that I think maybe what we need to do is to talk to Blue Cross and Blue Shield and other agencies of the Federal Government who are paying these claims to raise their consciousness and awareness of the fraud. Now one of the problems that Blue Cross and Blue Shield has had over the last year or so is slowness of payment.

The Members of Congress, including all of the Florida delegation, we have called them on the carpet to try to get them to expedite it, and they have improved considerably. However, I do not want the speed of payment to interfere with the accuracy of payment, particularly when we are talking about such sums of money as we are talking about.

Let me go back a little further in your testimony when you talked about doctors receiving kickbacks. Specifically, what does the law say about that?

Mr. COTTOS. Well, the law says that any gratuity that they get for a referral—for instance, if a doctor refers to a particular lab, and if that lab is paying him for those referrals, then that's illegal. Any kind of a gratuity is illegal, and that's a violation of the statute.

Mr. SHAW. That is a violation of the criminal statute. Is that not correct?

Mr. COTTOS. That is correct.

Mr. SHAW. So these doctors are committing crimes.

Mr. COTTOS. That's correct, sir.

Mr. SHAW. I assume that has something to do with the situation over in Tampa.

Mr. COTTOS. Yes, sir, it does.

Mr. SHAW. What is the penalty for this crime?

Mr. COTTOS. The penalty is 5 years in jail and $5,000 per count.

Mr. SHAW. So this is really quite a serious felony.

Mr. COTTOS. It's a felony. Yes, sir.

Mr. SHAW. I think I have heard of an investigation that you had in Philadelphia of a number of physicians mixed up in this, and that you found great eagerness——

Mr. COTTOS. Yes, sir.

Mr. SHAW [continuing]. On the part of the physicians to come back and reimburse the Federal Government. Are you personally familiar with that case?

Mr. COTTOS. Yes, sir. I'm very familiar with it.

Mr. SHAW. Not disclosing any secrecies, but tell us what you might be able to tell us about that particular case.

Mr. COTTOS. Yes, sir. It is a closed investigation so we can talk fairly freely about it. It's not an ongoing investigation. There was a lab called Medical Diagnostic Services in the Philadelphia area which was formed by two gentlemen with no medical background. And basically, they bought a machine that would do a blood flow test.

Chairman PICKLE. What kind of test?

Mr. COTTOS. Blood flow test. The machine basically cost them $3,000. And what they would do is go out to doctors' offices and tell doctors for every patient that they referred to them and allowed them to do this test on, they would give the doctor $50. Unfortunately, this test was not reimbursable by Medicare, so the test was worthless. To get it paid by Medicare, they called it something else. They called the test something that it was not. So it was twice worthless.

Basically, when we got involved with the investigation we found out what was going on. We identified the owners. We convicted the owners, and after their conviction they agreed to cooperate with us to minimize their sentencing. And what they did was give us a list of the doctors that they had paid kickbacks to. Now, the list was almost 900 doctors, so it is absolutely impossible for us to prosecute 900 doctors. But the U.S. attorney's office was concerned about trying to get the message across. Again, as I mentioned earlier, the doctors are critical in this type of system.

Mr. SHAW. Do you mean 900 doctors in the Philadelphia area?

Mr. COTTOS. Yes, sir.

Mr. SHAW. How many doctors are there in the Philadelphia area?

Mr. COTTOS. Well, this is Philadelphia, New Jersey, and Delaware.

Mr. SHAW. Oh, the region.

Mr. COTTOS. In the regional area, yes, sir. Basically, what the U.S. attorney's office decided to do was they broke the groups down. All of the doctors that had gotten more than $3,000—and there were approximately 25 of those—they decided to go after criminally. The rest of them that got between $150 and $3,000, they decided to go after civilly. And the civil division of the U.S. attorney's office sent letters out to each of these doctors telling them about the conviction if they didn't already know about it, and saying that we had the records and we knew how many tests that they had been paid for. And we asked for twice the amount they had been paid for plus a fine on top. We gave them 2 weeks to send the check in. If they did not send the check at that time, we would file suit civilly against them.

We had no idea what the reaction was going to be. We sent out 375 letters, and within 2 weeks we got back about 356 checks in the mail. What was interesting was approximately 35 doctors came in with their attorneys to look at the information. The rest of them just automatically sent checks in. Those that did not send checks initially, we ended up filing suit on in Philadelphia, and they all settled. None of them ended up going to a trial on it. Altogether, we recovered almost $700,000 on this project.

And some of the anecdotes that came out of it was one doctor called up and said, "This is the amount I owe you for MDS Lab. How much do I owe you for ABC Lab? I'd like to get rid of all this stuff right now." So they identified some other people that were doing similar things out of this project.

Mr. SHAW. I would think that we may very well have a similar or parallel situation going on all over the country because of the way that these mobile labs operate. Do the mobile labs, in your opinion, have any useful purpose?

Mr. COTTOS. If the quality of the lab work is good, then yes, the mobile labs would have a purpose—to get out to people who may have a problem going to a regular doctor's office to get lab work. Then it would be useful. What we have found in our studies and our investigations is that most of the medical labs have poorly trained personnel conducting those tests, and therefore, the results are basically worthless.

Mr. SHAW. Just one more area that I just want to touch on, and that is the question of free cholesterol checks. If somebody comes into a mobile lab as a Medicare recipient, and they offer to do anything on you for absolutely free, whether it be blood pressure, whether it be some type of blood analysis, what is the implication of that even if they do not go any further?

Mr. COTTOS. Well, that's a false statement to the recipient because it is not free. Medicare is going to pay 80 percent of what's billed. The patient is supposed to pay 20 percent. So when someone automatically waives that deductible, that's a red flag for us because they don't want that person looking at the bill.

Mr. SHAW. That is the point I want to make, too. It also ought to be a red flag for the senior citizen that they are dealing with a bunch of crooks at that particular time, and the best thing to do is either call you, call me, or just get away from them period.

Mr. COTTOS. That's absolutely correct, sir.

Mr. SHAW. Thank you. Thank you, Mr. Chairman.

Chairman PICKLE. Well, Mr. Cottos, I have several questions I want to ask you for the record, but first let me ask you: You are out of the Atlanta office.

Mr. COTTOS. Yes, sir.

Chairman PICKLE. What kind of staff do you have in the Atlanta office?

Mr. COTTOS. I cover 8 States out of the Atlanta office, starting at Kentucky and coming down the east coast, over to Mississippi, down through Florida. I have 42 investigators to cover those 8 States. I have 14 investigators in the State of Florida, and that's a very small staff because we have not only Medicare and Medicaid fraud, but we also have all the fraud in the Social Security area plus the other 285 programs that are paid for by the Department of Health and Human Services. We are responsible for all the fraud in the Department.

Chairman PICKLE. I do not think the answer to this is that you need more people, but I would ask do you need a larger staff?

Mr. COTTOS. Absolutely, sir. We could do a lot more if we had a larger staff, obviously.

Mr. SHAW. We could probably pay for that staff many times over by the moneys we've seen.

Mr. COTTOS. In the past semiannual report that the inspector general released, I think he was showing that we're recovering $85 for every dollar on our budget in the last year.

Chairman PICKLE. I am bothered that you have got a relatively small staff covering an 8 or 10 State area, representing millions of people with these types of cases happening. Your staff is too small. Even when you make these investigation and you make these charges, there are no indictments or it is slow coming out. You have collected some funds. You have collected upward of $100 million-plus, according to the record, and yet we are talking about perhaps $100 billion involved.

Mr. COTTOS. That's correct.

Chairman PICKLE. It would seem to me like the public is not being protected. If a mobile lab comes into this area, do they have to have a license from somebody?

Mr. COTTOS. No, sir, they don't.

Chairman PICKLE. Does Broward County have a mobile lab unit that they sponsor?

Mr. COTTOS. That, I don't know.

Chairman PICKLE. Does the city?

Mr. COTTOS. I don't know the answer to that.

Chairman PICKLE. You do not know.

Mr. COTTOS. No, sir.

Mr. SHAW. I don't believe they do.

Chairman PICKLE. So an individual company can organize a mobile lab.

Mr. COTTOS. That's correct.

Chairman PICKLE. And just show up.

Mr. COTTOS. That's correct.

Chairman PICKLE. Now, in this particular case here in Fort Lauderdale, they came into sort of a mobile park area. How did they get in to begin with? Did somebody make contact with a resident and sold them on the idea?

Mr. COTTOS. That's basically how they do it. They know where the senior citizens reside. And they can just go into that neighborhood and start making their pitch for whatever equipment or testing they have.

Chairman PICKLE. I want to get in to hear these individual persons who were involved, and I am going to do that. But it disturbs me very much that we have a staff that is too small, and then when we find fraud—seems no action. It seems to me that Blue Cross and Blue Shield are more interested in making payments than they are in helping to find the crooks. We will be talking to Blue Cross and Blue Shield later, and I do not think this committee ought to try to say where the fault is, but we are trying to find out what can be done to stop it, and how we can improve this to safeguard the public.

Now, I have some specific questions I want to ask you on this thing. First let me turn to your testimony, page 10. This is in respect to the billing procedure. You said:

> In recovery billing, companies review provider records over a specified period and identify the unbilled services. These unbilled services are submitted to the third party payers for reimbursement. Teaching providers and billing services how to recover billings by dealing with the Medicare coding system has led to a booming business for some medical businesses and consultants.

Now, it seems to me like you are saying that professionals had been organized to tell physicians exactly how they ought to bill, and physicians, in turn, say I don't want to fool with this billing. It's technical, and it's detailed, and it bothers me. I want to practice medicine. I don't want to fill out forms, but I want my money, and you bill for me. And you turn over to that billing agency. Now, here in Florida, you gave me in one of your investigations some examples of how they bill. Instead of billing you for a 3 millimeter mole, they upcoded it and they billed it for some kind of 2 centimeter mole.

But, no matter, that is what they have done. Now, you have made an investigation of it and found that it was wrong and illegal.

Mr. COTTOS. That's correct, sir.

Chairman PICKLE. Now, this was a professional billing service, was organized, and I can see why it might be of help. But the tendency would be to set up a system that you are going to get all the money possible from the Federal Government.

Mr. COTTOS. Yes, sir. That's correct.

Chairman PICKLE. That is pure and simply to milk the system.

Mr. COTTOS. That's exactly correct, sir.

Chairman PICKLE. Now, in this case they were apprehended. These were professionals. They were not just unlicensed people;

they were professional people. Was any indictment made in that case?

Mr. COTTOS. The outfit you're talking about is out of Massachusetts, and there has been an indictment in Massachusetts. It's continuing down here. There are several companies and individual physicians in the Miami area who were doing business with this company. And we are proceeding on those particular physicians right now. The company, itself, has been indicted in Massachusetts, and they're pending trial right now.

Chairman PICKLE. But still pending.

Mr. COTTOS. That's correct.

Chairman PICKLE. Well, across the country, how prevalent are these mobile units?

Mr. COTTOS. I think that what we have found is California and Florida seem to have the largest share of the mobile units, and basically again that's because of the population, the large Medicare population in those two States. Most of the large scams, they will go to the places where they can get the most money, and unfortunately, Florida and California are the two States that seem to draw most of these.

Chairman PICKLE. There is no reason for me to assume that south Texas is 100 miles away from all known sin. If this is happening in Florida and this is happening in California, it is going to be happening in Texas, particularly the southern part of our State where we have almost as many retirees as you have here in Florida, and it is growing. So across the country, this type of practice is prevalent and is getting bigger all of the time. Is that your judgment?

Mr. COTTOS. It is being investigated throughout the country. I think that every one of our regions—I don't have the exact figures, but I know that all of our regions have cases open on mobile labs.

Chairman PICKLE. Once more, do these mobile labs have to be licensed?

Mr. COTTOS. No, sir, they do not.

Chairman PICKLE. They can just come in as a mobile lab.

Mr. COTTOS. The Clinical Lab Improvement Act, which was passed in 1988, is trying to include some of the mobile labs, but right now, that seems to be a gray area about whether they should be included or not with the requirements under CLIA.

Chairman PICKLE. In our recent act, the very act you made reference to then, we tried to look at the question of pricing some of these services. Let us assume they were legitimate. Has that act gone into effect? Has there been a reduction in any of these charges that you know of, or can you tell?

Mr. COTTOS. Not at this time.

Chairman PICKLE. Can you tell me how your responsibilities as the inspector general differ from the payment safeguard activities carried out by the Medicare contractors?

Mr. COTTOS. The Medicare contractors, in processing the claims, should be able to identify some providers that are outside the normal parameters. In other words, when I talked about red flags or whatever, they have edits in their computers which indicate providers who are getting outside of the normal parameters. Normally, what their process is, is to follow up and see if it is not just an isolated instance. If they find some kind of a pattern, their job is to refer that to us, and then it is our job to investigate it and determine whether it should be handled criminally, civilly, or administratively.

Chairman PICKLE. What can be done to improve the fraud and the abuse activities of these contractors?

Mr. COTTOS. One of the things that I mentioned is a unique provider identification number. One of the other things that we would like to see is that the Office of Inspector General have direct access to the carrier data. If we had computer access to the carrier data, we would not have to call up the carrier and say get this information for us. We would be able to access it ourselves, which would eliminate the delays that we encounter. In different places, the delays vary. Some are very long; some are very short. But if we had access to that data ourselves, that would extremely streamline our process in getting those documents.

We can't do the investigations. If you tell me now that someone performed a test on you which wasn't necessary yesterday, I still have to have a claim in my hand to be able to take to a prosecutor and say this claim is false for this reason. So I have to have those documents to see exactly what was charged before I can make any kind of an investigation, and that's one of the problems that we're having.

Chairman PICKLE. It would seem to me that the procedure we have is really no procedure at all. If an individual or a company can be formed to move in as a mobile lab either by vehicle or just "invading like a team from Mars a particular site," then it is just wide open.

Mr. COTTOS. That's correct, sir.

Chairman PICKLE. And Medicare is literally hanging an invitation out for the con artists to come in and milk the system. Now the system is paying out—how much did you say, $100 billion a year?

Mr. COTTOS. That's correct, sir.

Chairman PICKLE. It is the fourth largest expensive medical care cost in all the Government—not medical, in all of the Government: defense, Social Security and interest on the national, and Medicare. And within the next 10 years, the Medicare health cost is going to outstrip all of them.

Mr. COTTOS. That's correct.

Chairman PICKLE. Anytime you have that much money, you are going to have con artists out there trying to grab it.

Mr. COTTOS. That's correct.

Chairman PICKLE. And with no procedure, no licensing required, with no regulation, is it any wonder then that people are coming in and beating the system out of its money.

Mr. COTTOS. Sir, we make recommendations. One of the ways that our agents differ from an FBI agent or any other law enforcement agent is when our agents work an investigation, at the end of that investigation they write what we call a management implication report. In that management implication report, they give the controls that were in place, how those controls were circumvented, and then make recommendations about how those loopholes can be closed. When they get those reports in Washington, they check and see if this is just a problem, for instance, in south Florida, or if it's a national problem.

If it's a national problem, we refer those to the Health Care Financing Administration. It's up to the Health Care Financing Administration to make the changes. We do not have the authority to make those changes in the coverage to the areas you are talking about.

Chairman PICKLE. All right. Let us explore that just a minute.

Mr. COTTOS. Yes, sir.

Chairman PICKLE. What can Congress do to change this system? You say you make the investigation. You make your report both to the local authorities and you pass your report on to HCFA.

Mr. COTTOS. Yes, sir.

Chairman PICKLE. Now, what changes should be made to implement these corrections? What can we, the Congress, do? Can you give us some suggestions?

Mr. COTTOS. Yes, sir. I think one of the areas would be to recommend that the physicians actually sign the prescriptions before durable medical equipment is issued to people. What we have found in the past is the equipment for instance, the seat lift chair, a TENS unit, whatever, is given to a recipient. And then the dealer takes that prescription to the physician and says please sign this so that your patient can have this equipment.

Chairman PICKLE. How can a physician sign that certificate afterwards when he had not seen the patient?

Mr. COTTOS. The problem is from the physician's point of view. If they say we gave it to your patient free, they are enjoying the seat lift chair, it's very comfortable, and if you don't sign it, we'll just get some other doctor to sign it.

Chairman PICKLE. So the physician signs it.

Mr. COTTOS. The physician signs it, basically. Now, we've tried to stop that. New York was the first place on seat lift chairs that we recommended a followup form before the carrier paid for that seat-lift chair, but we send a form to the doctor and let the doctor fill out some more detailed information about why this chair was necessary. What they found out was in the first 6 months that this form was introduced, the seat-lift chair claims went down 90 percent because doctors were very reluctant to fill out something when they hadn't seen the patient. If there was no followup, then it was no cost to them. They just signed it.

Chairman PICKLE. When you say the doctor was reluctant to sign this certificate——

Mr. COTTOS. Of medical necessity.

Chairman PICKLE. Now, do they sign it?

Mr. COTTOS. Not anymore. Not in New York they don't. Unfortunately, in several other places, they do. For instance, for the TENS the normal treating physician for a patient does not sign for it because it is not necessary.

Chairman PICKLE. In other words, if the physician had to sign that order ahead of time——

Mr. COTTOS. He would not do it.

Chairman PICKLE. He would not do it, or at least, it would slow it down greatly.

Mr. COTTOS. That's correct, sir.

Chairman PICKLE. All right. You have just said now that one thing to do is get some kind of regulations on these units that are coming into our neighborhood.

Mr. COTTOS. That's correct.

Chairman PICKLE. Where would they be licensed? Locally?

Mr. COTTOS. Probably Federal requirements for licensing would be a lot easier to enforce because if you go locally, then you have every State doing it differently, every locality doing it differently. I think if it were federally regulated, you would have better control on those types of things.

Chairman PICKLE. We will look into that. I do not think we want to just automatically set up a Federal regulation without working through the local community. But in some way, there ought to be regulations. There are no regulations now.

Mr. COTTOS. That's correct, sir.

Chairman PICKLE. I think Mr. Shaw said the provider can actually go into operation and get his number, a provider number, easier than he can get a VISA card or a Social Security card.

Mr. COTTOS. That's absolutely correct.

Chairman PICKLE. Now, that is shocking.

Mr. COTTOS. Yes, sir.

Chairman PICKLE. This is a permit to rip off millions of dollars from the system.

Mr. COTTOS. That's correct, sir.

Chairman PICKLE. Mr. Shaw, do you have any other questions?

Mr. SHAW. Just to follow up on a couple of items. Are physicians required to be State licensed before they can get a provider number?

Mr. COTTOS. Yes, sir, they are supposed to be. But if someone sends in a claim and says they are Dr. so-and-so, if the carrier doesn't have a provider number, they will issue one and then send out an application later on.

Mr. SHAW. Why on earth would we not get the States to do that as part of the licensing procedure, to give a Medicare provider number? Let the States do it.

Mr. COTTOS. Well, the State physician——

Mr. SHAW. An area physician in Florida could have an FL number, everyone in New York could have an NY number. Do it that way.

Mr. COTTOS. Right now, the State has the Medicaid number. Physicians have a Medicaid number and a Medicare number. Again, part of this unique physician identification number idea was you would have one number that you would use for tracking purposes. Right now, you have a Medicaid number, you have a Medicare number. If you have several offices, you can have one number for your office in Fort Lauderdale. If you have another office in Miami, you can have a separate provider number for the office in Miami.

Mr. SHAW. But there is no reason to have a separate provider number—I mean, you could have 10 offices and all of them have the same provider number. Is that correct?

Mr. COTTOS. I totally agree, sir.

Mr. SHAW. One of things which really concerns me more than anything else is how this thing is totally unregulated. Some of these people who were performing these types of mobile facilities here in Fort Lauderdale were actually set up in city facilities and were not even licensed by the city of Fort Lauderdale with an occupational license. Then, I think when you get into a situation where the senior citizen is coming into one of these mobile labs, they show themselves as being eligible for Medicare as a Medicare provider.

People all across this country naturally assume that if these people can be reimbursed by Medicare, they are approved by Medicare. There is no reason for them to think otherwise, but that is not the case. They are a bunch of crooks, and it is a big scam and a big fraud that they are perpetrating, not only on the Federal Government, but on the people who are supposed to be receiving this particular care and all of these tests. And they are sometimes not doing the testing, and sometimes people that are administering the tests are totally incompetent and do not know anymore about medicine than the chairman and I know. Is that not quite possible, the way the system is?

Mr. COTTOS. That's quite possible. There are certainly a lot of loopholes in the system.

Mr. SHAW. You have found that to be the case in much of your investigations. Is that correct?

Mr. COTTOS. That's correct, sir.

Mr. SHAW. So it is just a total fraud on the senior, and it is a fraud on the Federal Government.

Mr. COTTOS. And the Federal Government is paying for it. That's correct, sir.

Mr. SHAW. Thank you. Thank you, Mr. Chairman.

Chairman PICKLE. Before you leave, Mr. Cottos—and incidentally, I wish you would stay here for the conclusion because we may want to come back and ask you additional questions about way of coordination with these other agencies.

Mr. COTTOS. That's fine, sir.

Chairman PICKLE. Can you tell me more about your need to get access to Blue Cross and Blue Shield records? I am talking about access to their particular data base.

Mr. COTTOS. What we would like to do is to be able to have computers in each of our States with each of our carriers so that we can access that data from our offices so that we don't have to call the carrier up and request documents and wait for those documents to be sent to us. But rather, we can access that material ourselves. We don't need to input anything. We just need to be able to draw that information out.

Chairman PICKLE. Can you get that information now?

Mr. COTTOS. Right now, we can't. No, sir.

Chairman PICKLE. Does Blue Cross——

Mr. COTTOS. We have to get it from them when they get around to it.

Chairman PICKLE. Will they give it to you eventually?

Mr. COTTOS. Eventually, yes, sir.

Chairman PICKLE. What do you mean eventually?

Mr. COTTOS. Well, it can vary. We have records that we requested over 6 months ago that we have still not received from the carrier. We have other cases where we get records within a month.

Mr. SHAW. Is that Blue Cross and Blue Shield that you are referring to?

Mr. COTTOS. That's correct, sir.

Mr. SHAW. That's not rigid.

Chairman PICKLE. Can you tell me exactly how should the process work for obtaining a provider's number?

Mr. COTTOS. Well, what we have is a form where they have to give their complete background, you know, where they went to medical school, what license.

Chairman PICKLE. Now you are talking about the provider.

Mr. COTTOS. We would also like to see that for durable medical equipment dealers, for mobile labs, for everyone to show their background and show their qualifications.

Chairman PICKLE. There is no form now.

Mr. COTTOS. No, there's not, sir. No, there's not. It varies from carrier to carrier.

Chairman PICKLE. By provider now, who do you call the provider?

Mr. COTTOS. Anyone that is billing the Medicare system.

Chairman PICKLE. Specifically, would the provider be more the physician or the person who actually renders the service?

Mr. COTTOS. It can be a physician. It can be a mobile lab. It can be a durable medical equipment dealer. Anyone that is providing some service that Medicare reimburses is a provider.

Mr. SHAW. I think what we have found here, Mr. Chairman, is anytime anyone starts feeling the heat behind them, they simply change their name and get another provider number. Is that not correct?

Mr. COTTOS. That's a fair statement.

Mr. SHAW. So they are just staying one step ahead of you, and it is just a question of when you can close up your case.

Mr. COTTOS. That's correct.

Mr. SHAW. As far as the access to the computer, my office right here in Fort Lauderdale, through telephone lines, is connected to the computers in my Washington office. It's just as simple as that that you could be hooked up to the Medicare files at Blue Cross and Blue Shield. Is it not? Is there any difference?

Mr. COTTOS. No, not at all.

Mr. SHAW. And you have saved them the aggravation—what is the impediment against your just doing that?

Mr. COTTOS. The Health Care Financing Administration seems to be the problem. We approached this when I first took over the Atlanta region 2 years ago. I sent a letter to the Florida carrier, and said this is what I would like to do. And they basically came back and said, that's fine but HCFA is our funding source, and therefore, it has to be approved by HCFA. And that's as far as we got. HCFA has held it up, which is part of our own Department.

Chairman PICKLE. Why did HCFA hold it up? Just because of the size and enormity of it, or they just do not have the people?

Mr. COTTOS. I don't think I can answer that, Congressman. I have had a problem with that. Several other of my counterparts around the country have requested that same data and have gotten the same thing, that HCFA stands in the way. It's not necessarily the carriers; it is HCFA standing in the way, and I don't know exactly the reason why.

Chairman PICKLE. You have reported to HCFA, for instance, on this little TENS instrument.

Mr. COTTOS. Yes, sir.

Chairman PICKLE. Here is an instrument that costs at Radio Shack or someplace——

Mr. COTTOS. $59.

Chairman PICKLE. $59.

Mr. COTTOS. Yes, sir.

Chairman PICKLE. Yet, it is billed out as if it were a $500 unit. Based on that, they literally milk thousands upon thousands of dollars for this one little instrument. Now you reported that to HCFA.

Mr. COTTOS. Yes, sir, we have.

Chairman PICKLE. Did HCFA do anything about it? Have they given any instructions or passed any regulations?

Mr. COTTOS. At this point, they have still not reduced what they are paying. They are still paying $500 for the machine, and what they are saying is that——

Chairman PICKLE. Why does HCFA not do something about that? Why will they not put a stop to kind of thing?

Mr. COTTOS. Well, that's a question you'll have to ask them, Congressman.

Chairman PICKLE. Or we could ask why does Congress not put a stop to it.

Mr. COTTOS. Well——

Chairman PICKLE. So I am not trying to just point at HCFA alone.

Mr. COTTOS. Right.

Chairman PICKLE. But the system is uncontrolled.

Mr. COTTOS. There are definitely problems in the system. Again, we make recommendations to HCFA, but we cannot implement them.

Chairman PICKLE. Well, I want to hear this next panel, and I would like for you to stay if you will, Mr. Cottos.

Mr. COTTOS. Yes, sir.

Chairman PICKLE. Because we may want to come back to you and the panel with others, too. Can you do that?

Mr. COTTOS. Yes, sir. I sure can.

Chairman PICKLE. All right. We thank you very much for your testimony. Again, I want to say that your entire statement will be made a part of the record, and we thank you for your testimony this morning.

Mr. COTTOS. Thank you, sir.

Chairman PICKLE. Now the Chair would like to go to the next panel. I am going to ask now if these four persons will take a seat up here at the table. I want to ask Marjorie Throckmorton, Mary Carlson, Dr. Elly du Pré, and Sarah Donnelly. If each of you will come up here and take a seat at the witness table.

Mr. SHAW. Mr. Chairman, while they are sitting down, I think that what we are seeing with HCFA is something that I think is pretty widespread across the entire bureaucracy of the Federal Government. That is, people just do not want to do new things, that they have always done it one particular way, and they are satisfied with continuing to do it, and they are resisting any change, and particularly if that change comes at the suggestion of somebody from the outside even if that person might be a subpart of their particular organization.

Chairman **Pickle**. Well, I am sure you are correct about that, Mr. Shaw. This panel consists of four individuals who have been directly involved in this scam here in the Fort Lauderdale area. Our first witness will be Marjorie Throckmorton, who is a Medicare beneficiary. Then we will hear from Mary Carlson, another Medicare beneficiary, then Dr. Elly du Pré, who is the executive director of the Broward Center for Blind, and then Sarah Donnelly, special projects director of the Fort Lauderdale Housing Authority.

We appreciate very much each of you coming to be with us this morning. Now, first I am going to ask that we hear from Mary Throckmorton. Ms. Throckmorton, I understand you have a statement. If you would care to just present that and read the statement to us, we would be glad to receive that.

STATEMENT OF MARJORIE THROCKMORTON, COCONUT CREEK, FLA., MEDICARE BENEFICIARY

Ms. **Throckmorton**. Thank you, Mr. Chairman and Mr. Shaw.

Chairman **Pickle**. Let me ask you to pull that microphone up close to you and speak right into it, because we will not be able to hear you if you do not do that.

Ms. **Throckmorton**. My name is Marjorie Throckmorton and my husband, George, and I live in the Deerfield Lake Mobile Home Community in Coconut Creek, Fla. We moved from New Jersey to Florida in 1980 after we both retired.

Early in June, our community president was called by the Healthy Heart Program and asked if our residents would be interested in having a cholesterol test. It would be free; it would be done in our clubhouse. And it was discussed and decided that at "Koffee Klatch" on a Tuesday, when we have 40 or 50 or more residents assembled, would be a good time for us to have this free cholesterol test.

So on June 20, 1989, there were 40 or 50 of us there, and two gentlemen—I say that loosely—came to our clubhouse. One identified himself as a Dr. Barton, a retired doctor, and tried to impress us with the importance of having this cholesterol test, and also to know what our conditions were because at our age group, strokes and heart attacks are very prevalent, and any preventative things we can do are greatly to our benefit.

The tests were taken. They were computerized tests that actually took about 3 minutes, and they were done by this Dr. Barton and his associate. If the tests revealed a high cholesterol level or if you had been on medication for either heart conditions, blood pressure, circulatory problems, or anything of that nature, they said you would be eligible for future testing which would determine the condition of your arteries and possibly prevent heart attacks or strokes.

I had previously had a cholesterol test taken about 2 weeks before, and mine was a very elevated reading. And so I was interested in having a second opinion. So I had the cholesterol test, and it did agree with what my doctor's test had shown 2 weeks before. So I felt that the equipment was reasonably accurate and went along with the deal, thinking it was all legitimate.

The next day, June 21, the appointments had been given for when we were to come for the future testing on the following day. So on the 21st, we assembled at the clubhouse and we found, to our surprise, there were three portable tables set up since we didn't have any idea of what kind of tests were going to be taken. The three tables were set up and portable screens around them, which partially shielded each patient as they were on the tables.

The one associate that was there the previous day was taking our Medicare numbers and our contributory insurance number, private insurance numbers. The other man, who was later identified to me as a Dr. Rosenkrantz, was taking patient information to fill out the form for the patient acceptance form. He asked questions such as have you ever had dizziness, pins and needles, numbness, leg cramps, any kind of heart irregularities, and so forth. Well, at this age, who of us hasn't had some of those that would make us much eligible for these tests.

So after the forms were completed, the equipment being used by the three technicians that were there, we were told, was an Echo Doppler diagnostic recording equipment. And the tests that were done on me, I felt, were a very complete test where they did the carotid arteries, the heart arteries. They were done on me by a man. Then I went to the other tables and a woman did the lower extremities and leg arteries, and the whole test took about an hour and a half.

I was very impressed with the test. It gave an audible signal of your heartbeat and your blood flow, as well as a visual display on the scope, and it produced a tape which they wound up and identified at the end of the test. As I say, I was very impressed and thought this was an excellent test which should show any problems if you had them and would be very important for my doctor's information.

The reports were to be delivered to us since there were so many of us. They were to come to our clubhouse with the report and explain them to us within a 2-week period. After 2 weeks had expired and we had heard nothing, the chairlady of our "Koffee Klatch" called this Healthy Heart Program several times to try to find out when we would be receiving the tests, and was told each time that they were still in the process of being made up.

The final blow to me was on July 31; my husband and I received reports in the mail of explanation of benefits paid by Medicare. The total bill submitted for me to Medicare was $3,255, of which Medicare had actually paid $1,365.05. My husband's amount——

Chairman PICKLE. Let me interrupt you to be certain. The lab that showed up was called Omnisonics.

Ms. THROCKMORTON. Omnisonics, yes.

Chairman PICKLE. Your first tests were done in June.

Ms. THROCKMORTON. June 21.

Chairman PICKLE. 20th and 21st. And then here a couple of weeks later, or by the end of July you got a copy of the bill that showed Omnisonics had billed Medicare for $3,255. Medicare just automatically approved $1,780.

Ms. THROCKMORTON. Correct.

Chairman PICKLE. And they paid $1,365.05.

Ms. THROCKMORTON. Correct.

Chairman PICKLE. And showed a balance of some $400 to you.

Ms. THROCKMORTON. Correct.

Chairman PICKLE. Now, this was without any follow through, any visitation. It's just automatic billing.

Ms. THROCKMORTON. Right.

Chairman PICKLE. Apparently, they examined you, conducted these tests, and immediately starting billing right after that. And they paid out, in your case, $1,365.

Ms. THROCKMORTON. Correct.

Chairman PICKLE. I guess similarly, they made the same kind of a charge to your husband.

Ms. THROCKMORTON. Correct.

Chairman PICKLE. In effect, the same amount of money.

Ms. THROCKMORTON. $1,284.08 was paid by Medicare for my husband. Now, let me backtrack a little bit. Dr. Rosenkrantz took down the information of what symptoms you had, but he gave me no examination. There was no physical examination, no blood pressure check, no heart or lung check or anything of that nature. He did take some people's blood pressure. However, he did not take my husband's or mine.

Chairman PICKLE. What did he do for you or to you?

Ms. THROCKMORTON. He asked have you ever had any of these symptoms and filled out the form. That's all.

Chairman PICKLE. That was it?

Ms. THROCKMORTON. That was it.

Chairman PICKLE. The Government paid out $2,500 for that question.

Ms. THROCKMORTON. Well actually, they paid to Dr. Rosenkrantz—his bill of $250 came to me later, and they paid him $103.44 for asking me those questions.

Chairman PICKLE. That is for consultation.

Ms. THROCKMORTON. For consultation.

Mr. SHAW. What happened to Dr. Barton? You switched doctors on us.

Ms. THROCKMORTON. Well, Dr. Barton——

Mr. SHAW. You never saw him again.

Ms. THROCKMORTON. Dr. Barton was short lived. Dr. Barton was there on the first day that the cholesterol tests were taken.

Mr. SHAW. That is all he did.

Ms. THROCKMORTON. That's the only time we ever saw him.

Mr. SHAW. And Rosenkrantz came back with the machinery.

Ms. THROCKMORTON. Rosenkrantz—I was not even aware of his name. He didn't introduce himself—possibly, he did introduce himself. But when you are nervous and don't know exactly what's coming on, the mind has a way of making you forget things. But anyway, on August 8, I had a call from Dr. Rosenkrantz's office billing clerk asking me for my supplemental insurance carrier's number because having worked for the New Jersey Highway Authority, they cover their own insurance. And I had given them the name and my identification number, but they apparently goofed up their information and so they were calling me for the identification.

And at that time, I asked when the reports would be forthcoming, and the billing clerk did not know. However, she would ask Dr. Rosenkrantz and get back to me, which was never done. On August 14, his office called again for that information, which I again refused to give until I received some kind of reports. I also asked her about the exorbitant costs of the tests, of which she knew nothing.

On August 17, I received a report from Medicare on a bill for $250 explaining what they had paid this Dr. Rosenkrantz. The previous bills from Omnisonics plus this bill from Rosenkrantz, I knew something was radically wrong since we had not gotten any kind of reports. I called Dr. Rosenkrantz's office and got no satisfaction. He was not available nor was any information available on the tests.

So I called the inspector general's hotline for Medicare abuses and talked with a person there and asked what procedure I should follow to report this possible abuse. I had no way of knowing the full extent of possible abuse of the system, and she said to write a letter giving the information that I had just stated to her, which I did. I sent the letter on August 18, explaining how the whole operation had happened and the fact that no reports had been received, and yet exorbitant bills had been paid by Medicare.

Mr. **Shaw**. Was that hotline into Blue Cross and Blue Shield?

Ms. **Throckmorton**. No. That hotline is into the Baltimore office of the Department of Health and Human Services inspector general hotline in Baltimore.

Mr. **Shaw**. How did you know to call that number?

Ms. **Throckmorton**. My husband had found in the Medicare book the number to call for abuses of the system. So that's where I called, and then sent the followup letter. I sent it registered receipt requested to make sure it got there, and I know somebody got it.

On August 21, we received a letter from Blue Cross and Blue Shield of New Jersey, by which my husband is insured, with the attached bills that Omnisonics had forwarded to them for the balance of the payment due. They had sent it to the wrong office, to the wrong address, with the wrong identification. So Blue Shield was sending it back to us for proper identification.

So I called our carrier's office, Blue Cross and Blue Shield, or actually, I called the New Jersey Health Benefits Office. And I also called my insurance carrier, New Jersey Highway Authority, explaining the situation to both of them and asking them to withhold any payments until it was determined whether these were creditable outfits that should be paid or not, that I believed there was abuse of the system and a scam to just get the money.

On August 31, Dr. Rosenkrantz's office called me again, and I told the girl that I was instituting an investigation because things were definitely out of line and that——

Chairman **Pickle**. Did the call come from Fort Lauderdale locally, so far as you know?

Ms. **Throckmorton**. I believe from his Miami office.

Chairman **Pickle**. All right.

Ms. **Throckmorton**. The original Healthy Heart Program that had started this whole business was listed only with a box number in Hollywood, so I don't know exactly where they are located, and Dr. Rosenkrantz's office was in Miami.

On September 5, we received reports addressed to Mr. and Mrs. Jorge Throckmorton—oh, incidentally, I forgot to mention: During the testing, while the three people, the three technicians, the one man and two women were doing these tests, the two women were conversing continually in their native Puerto Rican language. At one point, one apologized to me for them speaking Puerto Rican as opposed to English, but they said they were from the same location. So they were chit-chatting the whole time that the tests were being taken, and the whole operation was very, very unprofessional, both in the ways the cots were set up——

Chairman **Pickle**. You are talking about part of the Omnisonics team.

Ms. **Throckmorton**. The Omnisonics team.

Chairman **Pickle**. They were speaking in Spanish or Puerto Rican language.

Ms. **Throckmorton**. Puerto Rican, Spanish.

Chairman **Pickle**. Yes.

Ms. **Throckmorton**. But the whole operation was so unprofessional in that we were partially disrobed in order for them to do these tests, and the three cots, while they had portable screens there, we were really not shielded from the other people who were waiting there for their appointments nor from each other. So the whole thing was completely unprofessional.

But anyway, the postmark on the envelope from these tests was August 31, which I felt meant that when they figured an investigation was going on, they got these reports out to my husband and me in a hurry. Nobody else, none of the rest of the residents, received any reports. We were the only two who did. Naturally, we couldn't decipher them ourselves, and we took them to our doctor, who read them over and said that the reports, he could not rely on. He said had he felt that we needed these tests, he would have sent us both to a lab that he could rely on. And so, therefore, anything that they said was so generalized that it didn't tell him anything important.

The more I got to thinking about it, the more irate I became. And so I called the AARP representative, Vernon Thornton, who's in charge of aiding seniors for any scams that are going on, and he referred our problem to the attorney general's office. I received a call from William Howell, who is consumer litigation section representative in the attorney general's office, and I explained the situation to him. He asked me to send a followup letter to him, which I did. On September 26, I received a reply from Mr. Howell, and he had contacted the Omnisonics attorney, who said that they would be glad to send a report to anybody who wished to receive a report. Now, when you spend $3,000 for reports, I think everybody wishes to receive some kind of reply on what those tests were showing. So that was really a—I, myself, was very irate at the response to that inquiry for help.

On October 10, I received another explanation of Medicare benefits. On the original bill to Medicare, there were two items that had been denied, two $210 items. And Omnisonics had rebilled for those two items, one of which was denied again by Medicare, and the second one a partial payment was made on. The same with my husband's bill. A $300 item had been denied as duplication on the first bill that we had received, and when it was resubmitted—oh, it had been broken down into two items on the second bill, one for $180 and also $120 under different codings. And the $180 item was honored, and $72 was paid on it. So after having been denied on the first bill, they resubmitted them to try to get more money.

Finally, after a few more calls to Dr. Rosenkrantz, on October 13, a lady by the name of Roni Hill came to our clubhouse with the balance of the reports for the other residents. Now, Roni Hill was a representative of the Essence Wellness Center, a nutritional center located here in, I believe, it's Fort Lauderdale. She was strictly a nutritionist and had no medical background to explain these reports to our residents. But what she did was read what the reports said, reviewed it with each resident, and that was the end of that.

Now, one of our residents said that a man had read the report to her. Her name is Thelma Johnson. I don't recall seeing a man there. However, in the confusion, there may well have been another man with Ms. Hill. And he explained to her that she had a slight problem in a carotid artery, but the chest arteries all looked good. Now, this lady had a major heart attack this past May with one artery being almost completely closed. And had those reports been of any value, it may possibly have eliminated the problem which she went through this May. But apparently, the tests did not show any kind of occlusion, and so she had to have angioplasty surgery in May.

The biggest problem with these tests—there were only a few people that I have talked to. I haven't talked with all of them that were tested—there were about 22 tested—because some of them were up north, some were on vacation, some of them just weren't available. But there are only a few of them who had taken the reports to their doctors for further analysis, which is another waste.

One man, Joseph Contino, took his report to the doctor, and the first doctor said, you know, whatever was in the report was not of any urgency, any problems. However, he went to a different doctor just a couple of months ago and took the report to him also, and he interpreted that there was a problem with a heart valve. So he called Omnisonics to try to get the original tape and original records that these reports were based on so that he could further evaluate and do a second evaluation on them, and was told by Omnisonics that they had no record of any Joseph Contino being tested. They had nothing they could send them because they had no records.

Chairman PICKLE. I want to thank you for that very full statement. May I ask you one question? I want to go to the other panel. You called the Office of the Inspector General in August.

Ms. THROCKMORTON. Yes, I did.

Chairman PICKLE. To ask them to look into this. Did you ever hear from the inspector general?

Ms. THROCKMORTON. No, I didn't.

Chairman PICKLE. No word from them.

Ms. THROCKMORTON. No.

Chairman PICKLE. All right. Thank you.

[The prepared statement follows:]

STATEMENT OF MARJORIE THROCKMORTON
Before the Committee on Ways and Means
Subcommittee on Oversight
July 30, 1990

My name is Marjorie Throckmorton and my husband, George, and I live in the Deerfield Lake Mobile Home Community in Coconut Creek, Florida. We moved from New Jersey to Florida in 1980 after we had both retired.

Early in June 1989, the Healthy Heart Program representative contacted the Deerfield Lake Mobile Home Community association president offering FREE cholesterol tests to our residents, available in our clubhouse.

June 20, 1989 - FREE cholesterol tests were done on approximately 40 to 50 residents after "Koffee Klatch."
June 21, 1989 - Echo Dappler diagnostic recorder tests were done on 22 people. Reports on tests were promised for delivery in two weeks. NO REPORTS WERE RECEIVED. Health Heart Program number was called several times by Koffee Klatch chairlady requesting reports.
July 31, 1989 - Reports received from Medicare Part B - Explanation of Medicare Benefits Paid for Marjorie Throckmorton.

To OMNISONICS:

Total Billed	Medicare Approved	Medicare Paid 80%	Balance Due
$ 2,425.00	$ 1,262.26	$ 1,009.82	$ 252.44
830.00	518.70	.27*	163.74
		354.96	
$ 3,255.00	$ 1,780.96	$ 1,365.05 (*interest)	$ 416.18

Paid for George Throckmorton To OMNISONICS:

$ 1,895.00	$ 1,128.39	$ 902.72	$ 225.67
830.00	518.70	381.36	137.34
$ 2,725.00	$ 1,647.09	$ 1,284.08	$ 363.01

August 8, 1989 - Dr. Rosenkrantz's office clerk called to request my supplemental insurance identification which I refused to give until I received some report of test results. Dr. Rosenkrantz was not available for discussion.
August 14, 1989 - Dr. Rosenkrantz's billing clerk called again for my insurance number.

August 17, 1989 - Report received from Medicare Part B - Explanation of Medicare Benefits paid for Marjorie Throckmorton:

To DR. ERIC ROSENKRANTZ for consultation:

Total Billed	Medicare Approved	Medicare Paid 80%	Balance Due
$ 250.00	$ 129.30	$ 103.44	$ 25.86

Paid for George Throckmorton To DR. ERIC ROSENKRANTZ for consultation:

$ 250.00	$ 129.30	$ 103.44	$ 25.86

August 17, 1989 - I called Dr. Rosenkrantz for an explanation of charges and lack of reporting but he was not available. I then called the Dept. of Health and Human Services Inspector General Hot Line in Baltimore, Md. to report this possible abuse of the Medicare system and fraudulent practice and asked for procedure to follow up.

August 18, 1989 - I sent a registered letter to H.H.S.O.I.G. Hot Line as instructed.

August 21, 1989 - Received correspondence from Blue Cross and Blue Shield of New Jersey with attached claim forms submitted by Omnisonic, Inc. requesting payment of balance due - $225.67 and $137.34 for George Throckmorton. Claims had been sent to wrong department with incorrect identification. Payment had not been made.

I called my husband George's New Jersey State Health benefits program and also my supplemental insurance carrier - New Jersey Highway Authority - and explained the possibility of fraudulent billing and requested their denial of payments to Omnisonic, Inc. and Dr. Rosenkrantz or any requests for payment of June 21, 1989 charges until their credibility is established.

August 31, 1989 - Dr. Rosenkrantz billing clerk called again. I told her I was instituting an investigation of their practice of submitting excessive bills but not delivering results.

September 5, 1989 - We received examination reports for Marjorie Throckmorton and JORGE Throckmorton that were postmarked August 31, 1989 from Dr. Rosenkrantz. I delivered these reports to our doctor for his evaluation. He said they had not been necessary. NO OTHER RESIDENTS RECEIVED REPORTS.

September 7, 1989 - I called AARP representative Vernon Thornton to report this fraud against seniors. He referred our problem to the Attorney General's office.

September 19, 1989 - Received a call from William Howell, Attorney General's office, Consumer Litigation Section. I explained our complaint and wrote a follow-up letter with copies of Medicare reports, bills and all correspondence attached, which was sent to Mr. Howell.

September 26, 1989 - Received a reply from William Howell. He had contacted Omnisonics attorney who requested a list of names and addresses of the residents who wish to receive test results. I referred Mr. Howell to our association president, Mr. W. Williams, who had a list of residents tested.

October 10, 1989 - Received another report from Medicare Part B - Explanation of Medicare Benefits paid for Marjorie Throckmortonl

To OMNISONICS (Duplication of charges denied on first bill)

Total Billed	Medicare Approved	Medicare Paid	Balance Due
$ 420.00	$ 192.20*	$ 76.88	$ 38.44
	(* 80% - 153.76)		

Paid for George Throckmorton (Duplication of charge denied on first bill) to OMNISONICS

$ 300.00	$ 180.00*	$ 72.00	$ 36.00
	(* 80% - 144.00)		

October 13, 1989 - Examination reports from Dr. Eric Rosenkrantz were delivered to our community clubhouse by Roni Hill, a nutritionist representing Essence Wellness Center. She had no medical qualification nor understanding to explain the reports to the residents tested. She explained she had no connection with Dr. Rosenkrantz or Omnisonics, other than to be hired just to deliver the reports and explain nutritional needs for wellness.

Our personal physician said these tests were not necessary for us and he could not rely on the reported evaluations.

Additional Notes on Billing:

August 24, 1989 - Dr. Rosenkrantz submitted bills to N.J. State Health Benefits for George for Medical Supplies - $129.30 and 120.70; total $250.00. Medicare had paid $103.44 and balance of $146.56 was denied.

November 13, 1989 - Omnisonics resubmitted bills to N.J. State Health Benefits for George for $120.00 and $180.00; total $300.00 for Assistant at Surgery. Medicare had paid $144.00. $156.00 balance denied.

Chairman **Pickle**. Now, I want to go on to the other witnesses. I want to ask that Mary—and if you will, Ms. Throckmorton, just remain there at the table. We will hear from Mary Carlson, who is a Medicare beneficiary. Ms. Carlson.

STATEMENT OF MARY L. CARLSON, FORT LAUDERDALE, FLA., MEDICARE BENEFICIARY

Ms. **Carlson**. My name is Mary——

Chairman **Pickle**. Before you start, let me see if I have—yes, I have a copy. If you would like to just read your statement, it will be all right. Get the microphone if you will, please.

Ms. **Carlson**. My name is Mary L. Carlson. I have been a resident of the Fort Lauderdale area since 1961. My late husband was a teacher at Dillard High School, and I taught at several of the schools before my retirement.

In addition to being an active member of Harris Chapel United Methodist Church and president of the choir, I am a member of the Keenagers, a social group of retired citizens. And I would like to state here that I am happy to see that two other members of that group came today in the audience, of these Keenagers.

Chairman **Pickle**. We are glad to have them here.

Ms. **Carlson**. And in November, the Keenagers were invited to participate in a free cholesterol screening at the Lauderdale Manors Recreation Center. Arrangements for this screening had been made with the parks and recreation department. We were told that the screenings would be free and that our doctors would be told of the results of the testing. I had also heard from such free screenings through an announcement at the church.

On November 6——

Chairman **Pickle**. Before you go on, I want to be sure that this group had been approved by the parks and recreation department.

Ms. **Carlson**. Parks and recreation, yes.

Chairman **Pickle**. Obviously of Fort Lauderdale.

Ms. **Carlson**. Of the city of Fort Lauderdale. We met every Monday, and like I said, I have two other members that can verify these statements concerning the Keenagers.

Mr. **Shaw**. Wait. Let me back up just a minute. The question was whether the screening had been approved by the city of Fort Lauderdale. I don't believe that's the case, but they were in a city of Fort Lauderdale facility. Is that correct?

Ms. **Carlson**. Yes. But we have one of the health directors here. I'm sure she can give you that answer——

Mr. **Shaw**. OK.

Ms. **Carlson** [continuing]. On the other side concerning whether it had been approved. I do not know because I just went in to cooperate with the group, with these doctors coming in to give these tests.

Mr. **Shaw**. Yes, ma'am. Thank you.

Ms. **Carlson**. We were told that the screenings would be free and that our doctors would be given the results of the tests. I had also heard from it from the church.

On November 6, 1989, the Keenagers—this is this group that went for the screening, about 25 of us for this screening. The screenings began with tests for blood cholesterol. Those of us which had the high cholesterol levels were asked to take additional tests. No one ever explained exactly what these tests were for, and to this day I can't tell you what I was really tested for.

The test equipment looked something like a television screen. One of the tests involved the upper body, in which you had to partially disrobe. The other test involved the legs area. There were about five people that conducted these tests. They all wore white coats, and I assumed that they were doctors. I trusted them.

I never heard any results of these tests. In about 3 weeks, however, I got the statement from Medicare that indicated that Medicare had been billed for $460 for diagnostic testing on November 6. This charge had been submitted by General Imaging. The statement indicated that I would be responsible for $46 of this amount.

I was surprised to see that Medicare had been billed for service on November 6 because I had understood that the screening was to be free. I was even more surprised about 2 days later. I received a second statement from Medicare indicating that an additional $1,910 had been billed by the same General Imaging for diagnostic x rays and laboratory services performed on November 6. This bill indicated that I would be responsible for $151.61.

Chairman PICKLE. Now, this bill for $1,910 was billed by this General Imaging for——

Ms. CARLSON. The same date.

Chairman PICKLE [continuing]. Services rendered to you.

Ms. CARLSON. Yes. All of this was the same date. We did not go any other day, just an hour, maybe approximately an hour and a half on this one day. All these bills were sent for this one day.

Several weeks later, I received a third statement from Medicare for the service that was rendered also on November 6. The services were described by another company, but it was on the same—the only way I knew it was the same company because it was on the same day. And this was the only day that we had done any testing—by Central Med Center. This was the name that they sent for this bill. However, no one had visited my home or any of the other homes in the organization during the cholesterol screening on November 6. The total amount billed to Medicare for the supposedly free screening totals were $2,465.

Chairman PICKLE. This charge is for services rendered you, or for the group?

Ms. CARLSON. For me. Each individual——

Chairman PICKLE. For you, individually.

Ms. CARLSON. Yes. I submitted to Congressman Shaw's office some of the statements from the others, the bills that they sent them. But this was only for myself, this one person within this same day, within these hours.

After receiving these Medicare statements, I brought them to the attention of my fellow Keenagers. Many of them had received similar statements. After this, I called Jacksonville, the Medicare office, and I was told to submit a written complaint, and they gave me the address to where I should write this. I wrote a letter to Medicare, Blue Cross and Blue Shield, and sent a letter that was cosigned by 15 of the fellow Keenagers. I did not receive any response to this complaint. However, I was informed that I would not be responsible for any part of the bills submitted by Medicare because——

Chairman **Pickle**. Did you ever receive a reply from Blue Cross or Blue Shield?

Ms. **Carlson**. No. No. The only thing——

Chairman **Pickle**. But they paid it.

Ms. **Carlson** [continuing]. That I received later after all of this was over was a statement on one of those bills saying that it had been—the liability had been lifted. So I assumed that that meant that they were no longer charging me the charges that they said on those letters.

Chairman **Pickle**. All they said was that you were not going to be responsible. That is all you——

Ms. **Carlson**. That's what it said, the liability was lifted. And I assumed that that's what it meant. But other than that, I did not receive a letter from them.

I went to the Congressman—well, the housing authority called Congressman Shaw's office and reported the situation. I went to the office later to verify the things that they had said for my own situation. And I hoped that we, together, would be able to stop this Medicare ripoff. I went to verify the reports that they had.

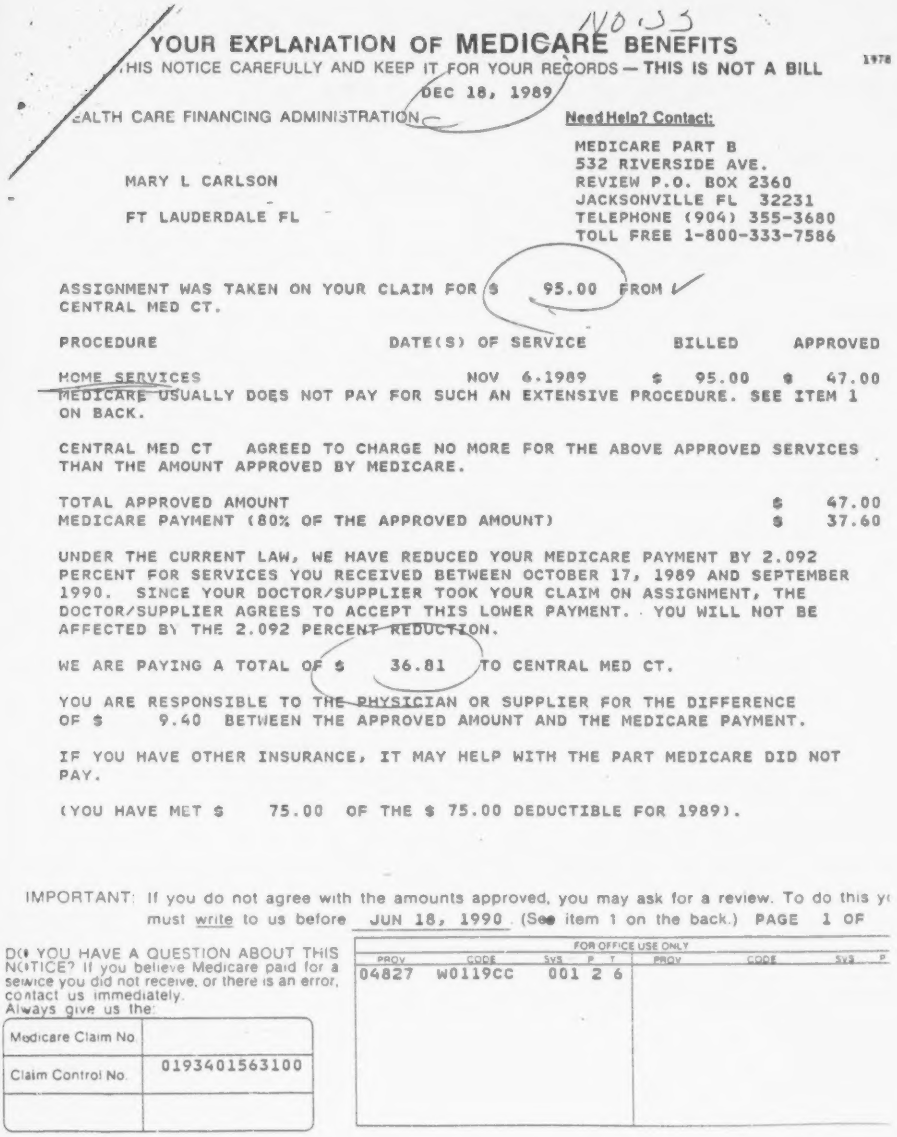
Now, I have here a copy of the bills that were sent. The first one was $460. The next one was $1,910, and the last one was $95 supposedly for home service. I never received any help or any report of the results of the testing.

Chairman **Pickle**. Ms. Carlson, we will insert for the record these bills, these statements that you received.

Ms. **Carlson**. Yes, sir. You have them. I think they made a copy, and they also have copies from some of the other people at the same organization.

Chairman **Pickle**. We thank you very much for your testimony.

[An attachment to the statement follows:]



NO.33

YOUR EXPLANATION OF MEDICARE BENEFITS

HIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — THIS IS NOT A BILL

1978

DEC 18, 1989

EALTH CARE FINANCING ADMINISTRATION

MARY L CARLSON

FT LAUDERDALE FL

Need Help? Contact:

MEDICARE PART B
532 RIVERSIDE AVE.
REVIEW P.O. BOX 2360
JACKSONVILLE FL 32231
TELEPHONE (904) 355-3680
TOLL FREE 1-800-333-7586

ASSIGNMENT WAS TAKEN ON YOUR CLAIM FOR $ 95.00 FROM ✓ CENTRAL MED CT.

PROCEDURE	DATE(S) OF SERVICE	BILLED	APPROVED
HOME SERVICES	NOV 6.1989	$ 95.00	$ 47.00

MEDICARE USUALLY DOES NOT PAY FOR SUCH AN EXTENSIVE PROCEDURE. SEE ITEM 1 ON BACK.

CENTRAL MED CT AGREED TO CHARGE NO MORE FOR THE ABOVE APPROVED SERVICES THAN THE AMOUNT APPROVED BY MEDICARE.

TOTAL APPROVED AMOUNT	$ 47.00
MEDICARE PAYMENT (80% OF THE APPROVED AMOUNT)	$ 37.60

UNDER THE CURRENT LAW, WE HAVE REDUCED YOUR MEDICARE PAYMENT BY 2.092 PERCENT FOR SERVICES YOU RECEIVED BETWEEN OCTOBER 17, 1989 AND SEPTEMBER 1990. SINCE YOUR DOCTOR/SUPPLIER TOOK YOUR CLAIM ON ASSIGNMENT, THE DOCTOR/SUPPLIER AGREES TO ACCEPT THIS LOWER PAYMENT. YOU WILL NOT BE AFFECTED BY THE 2.092 PERCENT REDUCTION.

WE ARE PAYING A TOTAL OF $ 36.81 TO CENTRAL MED CT.

YOU ARE RESPONSIBLE TO THE PHYSICIAN OR SUPPLIER FOR THE DIFFERENCE OF $ 9.40 BETWEEN THE APPROVED AMOUNT AND THE MEDICARE PAYMENT.

IF YOU HAVE OTHER INSURANCE, IT MAY HELP WITH THE PART MEDICARE DID NOT PAY.

(YOU HAVE MET $ 75.00 OF THE $ 75.00 DEDUCTIBLE FOR 1989).

IMPORTANT: If you do not agree with the amounts approved, you may ask for a review. To do this y must write to us before JUN 18, 1990. (See item 1 on the back.) PAGE 1 OF

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? If you believe Medicare paid for a service you did not receive, or there is an error, contact us immediately. Always give us the:

Medicare Claim No.	
Claim Control No.	0193401563100

FOR OFFICE USE ONLY

PROV	CODE	SVS	P	T	PROV	CODE	SVS	P
04827	W0119CC	001	2	6				

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — **THIS IS NOT A BILL**

NOV 25, 1989

HEALTH CARE FINANCING ADMINISTRATION

Need Help? Contact:

MEDICARE PART B
532 RIVERSIDE AVE.
REVIEW P.O. BOX 2360
JACKSONVILLE FL 32231
TELEPHONE (904) 355-3680
TOLL FREE 1-800-333-7586

MARY L CARLSON

FT LAUDERDALE FL

ASSIGNMENT WAS TAKEN ON YOUR CLAIM FOR $ 460.00 FROM ✓
GENERAL IMAGIN.

PROCEDURE	DATE(S) OF SERVICE	BILLED	APPROVED
DIAGNOSTIC X-RAY	NOV 6,1989	$ 230.00	$ 230.00
DIAGNOSTIC X-RAY SUBMITTED AS A DUPLICATE LINE ON SAME CLAIM.	NOV 6,1989	$ 230.00	$ 0.00

GENERAL IMAGIN AGREED TO CHARGE NO MORE FOR THE ABOVE APPROVED SERVICES THAN THE AMOUNT APPROVED BY MEDICARE.

TOTAL APPROVED AMOUNT	$ 230.00
MEDICARE PAYMENT (80% OF THE APPROVED AMOUNT)	$ 184.00

UNDER THE CURRENT LAW, WE HAVE REDUCED YOUR MEDICARE PAYMENT BY 2.092 PERCENT FOR SERVICES YOU RECEIVED BETWEEN OCTOBER 17, 1989 AND SEPTEMBER 1990. SINCE YOUR DOCTOR/SUPPLIER TOOK YOUR CLAIM ON ASSIGNMENT, THE DOCTOR/SUPPLIER AGREES TO ACCEPT THIS LOWER PAYMENT. YOU WILL NOT BE AFFECTED BY THE 2.092 PERCENT REDUCTION.

WE ARE PAYING A TOTAL OF $ 180.15 TO GENERAL IMAGIN.

YOU ARE RESPONSIBLE TO ~~THE PHYSICIAN~~ OR SUPPLIER FOR THE DIFFERENCE OF $ 46.00 BETWEEN THE APPROVED AMOUNT AND THE MEDICARE PAYMENT.

IF YOU HAVE OTHER INSURANCE, IT MAY HELP WITH THE PART MEDICARE DID NOT PAY.

(YOU HAVE MET $ 75.00 OF THE $ 75.00 DEDUCTIBLE FOR 1989).

MPORTANT: If you do not agree with the amounts approved, you may ask for a review. To do this you must write to us before MAY 25, 1990 (See item 1 on the back.) PAGE 1 OF 1

YOU HAVE A QUESTION ABOUT THIS
TICE? If you believe Medicare paid for a
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ntact us immediately.
vays give us the:

dicare Claim No	

FOR OFFICE USE ONLY									
PROV	CODE	SVS	P	T	PROV	CODE	SVS	P	T
V0901	76925	001	1	5					
V0901	76925	001	1	5					

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — **THIS IS NOT A BILL** 1192:

NOV 27, 1989

HEALTH CARE FINANCING ADMINISTRATION

Need Help? Contact:

MEDICARE PART B
532 RIVERSIDE AVE.
REVIEW P.O. BOX 2360
JACKSONVILLE FL 32231
TELEPHONE (904) 355-3680
TOLL FREE 1-800-333-7586

MARY L CARLSON

FT LAUDERDALE FL

ASSIGNMENT WAS TAKEN ON YOUR CLAIM FOR $ 1910.00 FROM ✓
GENERAL IMAGIN.

PROCEDURE	DATE(S) OF SERVICE	BILLED	APPROVED
DIAGNOSTIC X-RAY APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	NOV 6,1989	$ 490.00	$ 350.00
DIAGNOSTIC X-RAY ALLOWED AMOUNT DETERMINED AFTER MANUAL REVIEW.	NOV 6,1989	$ 300.00	$ 57.03
DIAGNOSTIC LAB APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	NOV 6,1989	$ 230.00	$ 175.50
DIAGNOSTIC X-RAY THIS IS A DUPLICATE OF A BILL OR CHARGE CURRENTLY BEING PROCESSED.	NOV 6,1989	$ 330.00	$ 0.00
DIAGNOSTIC X-RAY SUBMITTED AS A DUPLICATE LINE ON SAME CLAIM.	NOV 6,1989	$ 330.00	$ 0.00
DIAGNOSTIC LAB APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	NOV 6,1989	$ 230.00	$ 175.50

GENERAL IMAGIN AGREED TO CHARGE NO MORE FOR THE ABOVE APPROVED SERVICES THAN THE AMOUNT APPROVED BY MEDICARE.

TOTAL APPROVED AMOUNT	$ 758.03
MEDICARE PAYMENT (80% OF THE APPROVED AMOUNT)	$ 606.42

UNDER THE CURRENT LAW, WE HAVE REDUCED YOUR MEDICARE PAYMENT BY 2.092 PERCENT FOR SERVICES YOU RECEIVED BETWEEN OCTOBER 17, 1989 AND SEPTEMBER 1990. SINCE YOUR DOCTOR/SUPPLIER TOOK YOUR CLAIM ON ASSIGNMENT, THE

MPORTANT: If you do not agree with the amounts approved, you may ask for a review. To do this you must write to us before MAY 27, 1990 (See item 1 on the back.) PAGE 1 OF 2

YOU HAVE A QUESTION ABOUT THIS
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FOR OFFICE USE ONLY

PROV	CODE	SVS	P	T	PROV	CODE	SVS	P	T
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V0901	93320	001	1	5					
V0901	93910	001	1	8					
V0901	76925	001	1	5					
V0901	76925	001	1	5					
V0901	93890	001	1	8					

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — **THIS IS NOT A BILL**

11927

NOV 27, 1989

HEALTH CARE FINANCING ADMINISTRATION

Need Help? Contact:

MEDICARE PART B
532 RIVERSIDE AVE.
REVIEW P.O. BOX 2360
JACKSONVILLE FL 32231
TELEPHONE (904) 355-3680
TOLL FREE 1-800-333-7586

MARY L CARLSON

FT LAUDERDALE FL 33311

DOCTOR/SUPPLIER AGREES TO ACCEPT THIS LOWER PAYMENT. YOU WILL NOT BE AFFECTED BY THE 2.092 PERCENT REDUCTION.

WE ARE PAYING A TOTAL OF $ 593.73 TO GENERAL IMAGIN. ✓

YOU ARE RESPONSIBLE TO THE PHYSICIAN OR SUPPLIER FOR THE DIFFERENCE OF $ 151.61 BETWEEN THE APPROVED AMOUNT AND THE MEDICARE PAYMENT.

IF YOU HAVE OTHER INSURANCE, IT MAY HELP WITH THE PART MEDICARE DID NOT PAY.

(YOU HAVE MET $ 75.00 OF THE $ 75.00 DEDUCTIBLE FOR 1989).

IMPORTANT: If you do not agree with the amounts approved, you may ask for a review. To do this you must write to us before MAY 27, 1990 (See item 1 on the back.) **PAGE 2 OF 2**

) YOU HAVE A QUESTION ABOUT THIS
)TICE? If you believe Medicare paid for a
vice you did not receive, or there is an error,
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Control No	0393180143400

FOR OFFICE USE ONLY

PROV	CODE	SVS	P	T	PROV	CODE	SVS	P
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V0901	93320	001	1	5				
V0901	93910	001	1	8				
V0901	76925	001	1	5				
V0901	76925	001	1	5				
V0901	93890	001	1	8				

Chairman Pickle. Now, I would like to hear from Dr. Elly du Pré, executive director of the Broward Center for the Blind. Dr. du Pré.

STATEMENT OF ELLY DU PRÉ, PH.D., EXECUTIVE DIRECTOR, BROWARD CENTER FOR THE BLIND, FORT LAUDERDALE, FLA.

Ms. du Pré. Good morning.

Chairman Pickle. Good morning.

Ms. du Pré. I am Dr. Elly du Pré, and I am the executive director of the Broward Center for the Blind, where we serve blind and visually impaired persons in two different programs. One is a rehabilitation program, and the other is a recreation program.

Chairman Pickle. A little louder if you will, please.

Ms. du Pré. OK. Do you want me to just read this statement?

Chairman Pickle. Yes. I think that might be better, and then we may have questions.

Ms. du Pré. OK. Regarding the Healthy Heart Program, Mr. James Keogh made arrangements with our activities coordinator for free cholesterol testing for our clients to be held on November 27, 1989. Contrary to our agreement with Mr. Keogh, a "MASH team" of physicians and technicians entered our building and set up their equipment. Clients were asked to sign insurance forms, and this team told the clients that if they received any bills, they were to disregard them. This center looked like a hospital, and very little privacy was given to the clients being tested.

Clients were left partially disrobed in the hallway, waiting further testing, on the first day. I confronted Roni Hill, the nutrition counselor, with my suspicions about the program, specifically citing Medicare fraud and the unprofessional nature of the proceedings. This is when I arrived. I arrived later in the day than when they did because I was detained for a meeting earlier in Miami.

Chairman Pickle. Let me interrupt you here. You said you were confronted by Roni Hill, the nutrition counselor. Now, you were being examined by Healthy Heart Program, and Roni Hill then, as a nutritional counselor was, I assume, working for the Healthy Heart Program.

Ms. du Pré. That's what we believed.

Chairman Pickle. Though she was a nutritionist. Now, we heard from Ms. Throckmorton earlier that this same Roni Hill came to deliver the reports from Dr. Rosenkrantz personally, and said she did not know him or she was just delivering the reports and she did not know anything about it. And yet here, it shows that she is actually working for the organization. So she must have known Dr. Rosenkrantz or had some association with him——

Ms. du Pré. I didn't have any——

Chairman Pickle [continuing]. Or with the other group.

Ms. du Pré. I assume. I didn't have any testing done myself. Let me make that clear. But when I arrived at work later during the day—and they were packing up to leave at that time—she was there. I confronted her. She said that she was some kind of consultant working with them, and I told her that I didn't think that the proceedings were professional in any way, and that I was concerned that this was really a Medicare fraud type activity. And she said, "No, no, no, no. It's nothing like that."

Chairman PICKLE. But it would appear to me on the surface that Roni Hill was not any innocent messenger.

Ms. DU PRÉ. No.

Chairman PICKLE. She was in connivance with the whole operation.

Ms. DU PRÉ. Yes. We received a letter at the Broward Center for the Blind several months ago from Roni Hill with just a Post Office box number in Hollywood. And she was disavowing any real relationship with the group, but I mean she was closely involved with them that day.

I pointed out to Roni Hill at that time at that first visit that one of the pieces of testing equipment fell on the floor as it was being wheeled out of the building. And it seemed strange to me that such delicate equipment could withstand such rough treatment. But most important, I protested that the whole program was totally different from what had been offered and accepted originally. We only had accepted them to come in to speak about cholesterol and to do these free testings.

Mr. Keogh returned to the agency to apologize to me for any misunderstanding, and a return visit by the Healthy Heart team was permitted, really just to allow them to complete testing on people that they had already begun testing because there were so many people, they couldn't finish. And the clients were eager to receive their reports so I went along with it.

The second visit occurred on December 4 and repeated the chaotic atmosphere of the first visit. Clients, both men and women, were in the same large room—this one large room that we have—partially disrobed with minimal privacy screening. In some cases, only the doctors' bodies were providing any privacy. On this occasion, Dr. Barton introduced himself to me, and I told him I would not want to continue this program on any of the other days that clients attend our center. He tried to persuade me that our clients would benefit, possibly even being told of life-threatening conditions that might be undetected by their regular doctor. But I declined to invite them to return.

The actual tests conducted were cholesterol, carotid, echo, PVR—I don't know what that is—vascular, and EKG. The persons involved with this program as it was conducted on our premises were Doctors Alan Barton, Joseph Kaplan, Ralph Stantisti, Harry Lomont, a Dr. Pahor, and the nutrition counselor and psychoimmunologist, Roni Hill. These persons were assisted by five technicians, and our activities coordinator attempted to get their names. They only gave their first names so I didn't include them in this report. Except for Ms. Hill, everyone wore white coats and stethoscopes and were referred to as doctor.

None of our clients received any test results. All received bills or statements from Medicare and Blue Cross and Blue Shield, as well as other supplemental insurance carriers. These bills ranged from $1,900 to $3,200. Clients contacted, by phone and by mail, these insurance carriers and Medicare to report that this Healthy Heart Program is fraudulent. Medicare and the insurance carriers expressed no interest in the matter, and as recently as 2 weeks ago, a client came into my office and he's still concerned about this matter. And he told me that he still had received no response from Medicare regarding his lengthy written complaint in which he documented unprovided service and incorrect dates.

Chairman PICKLE. You say that Medicare and the insurance carriers expressed no interest in the matter. Did you report that to them?

Ms. DU PRÉ. The clients who were actually involved in what happened reported it to them.

Chairman PICKLE. Directly, you did not, but the people there at the Blind Center did report that to them, and they got no response from either Medicare or the inspector general's office. Is that correct?

Ms. DU PRÉ. Right. And when they got such poor response as that, then we contacted Congressman Shaw's office.

Chairman PICKLE. I notice you said that these people were identified as Doctors Alan Barton, Joseph Kaplan, Ralph Stantisti, and Harry Lomont. Were they all supposedly Fort Lauderdale physicians? Did you know any of them?

Ms. DU PRÉ. No. We did not know any of them.

Chairman PICKLE. You just assumed they were from this area.

Ms. DU PRÉ. Right.

Chairman PICKLE. But you did not know any of them. Now, let me ask you one other question. You are just the director of this blind institute or the group, and you were not examined. Were you?

Ms. DU PRÉ. No.

Chairman PICKLE. You protested after the first and second time that it was unprofessional and that you did not want them to come back, and yet they were billed. Can you give us, for the record, how much those people at that blind group were billed for the services or for these examinations?

Ms. DU PRÉ. It ranged.

Chairman PICKLE. Do you know the totals?

Ms. DU PRÉ. I could probably find out from the clients.

Chairman PICKLE. Would the staff know what the total would be? I would like to find out. I would just like to know the total billing applied to this blind group.

Ms. DU PRÉ. They ranged between $1,900 and $3,200, but I don't have copies of the bills.

Chairman PICKLE. For each person.

Ms. DU PRÉ. Each person got a bill somewhere in that range.

Chairman PICKLE. Blue Cross and Blue Shield shelled out—they paid for it without any proof, just receipt of billing from this group.

Ms. DU PRÉ. Right.

Chairman PICKLE. They paid off.

Ms. DU PRÉ. Right, even though they were getting complaints.

Chairman PICKLE. Holy mackerel.

Ms. DU PRÉ. I mean, a number of our clients are quite sophisticated, and they were contacting Medicare, in particular, to complain about it. And as the people who have already spoken indicated——

Chairman PICKLE. Well, tell me——

Ms. DU PRÉ [continuing]. They had to write letters about that, and they did.

Chairman PICKLE. Well, tell me now why did you agree to let this group come in?

Ms. DU PRÉ. We are often called and offered for speakers to come and speak to our agency on different issues. People come and talk about arthritis. They just talk; they make a presentation to the clients. And the original idea was that Dr. Barton was going to come and speak to the group about cholesterol. And every time you turned around, another thing happened.

Chairman PICKLE. Who contacted you?

Ms. DU PRÉ. James Keogh contacted our——

Chairman PICKLE. James Keogh.

Ms. DU PRÉ [continuing]. Activities director.

Chairman PICKLE. Did you know Mr. James Keogh?

Ms. DU PRÉ. No.

Chairman PICKLE. Was he a Fort Lauderdale man?

Ms. DU PRÉ. I don't think we asked where he was from. He indicated he was from the Healthy Heart Program, and they——

Chairman PICKLE. He just asked if you would be interested in having——

Ms. DU PRÉ. A speaker.

Chairman PICKLE [continuing]. A doctor and others come and conduct these tests. It would not cost you anything.

Ms. DU PRÉ. Yes. Initially, he was just going to come and speak about cholesterol.

Chairman PICKLE. And you said sure, why not.

Ms. DU PRÉ. Yes.

Chairman PICKLE. But other than that, there was no checking it out.

Ms. DU PRÉ. No.

Chairman PICKLE. All right.

Ms. DU PRÉ. Because we're dealing—our clients are adults, and they evaluate for themselves the information that they are getting, and they do quite well with their questions and with listening to the people reporting.

Chairman PICKLE. All right. I thank you very much.

Now, we have one other person to testify, and that is Sarah Donnelly, who is the special projects director of the Fort Lauderdale Housing Authority. Ms. Donnelly.

STATEMENT OF SARAH DONNELLY, SPECIAL PROJECTS DIRECTOR, FORT LAUDERDALE HOUSING AUTHORITY

Ms. DONNELLY. Mr. Chairman, Congressman Shaw, good morning. My name is Sarah Donnelly, and I am the special projects director for the Fort Lauderdale Housing Authority. My involvement in this was somewhat peripheral in that I was first contacted on January 17, 1990, by Suzanne McAllister, who is the community programs supervisor for the city of Fort Lauderdale Parks and Recreation Department. At that time, Ms. McAllister inquired of me whether or not I was familiar with an organization known as the Healthy Heart Institute. I replied to her that I had not heard of them prior to that time, and she indicated that they were using the Housing Authority as a reference on a solicitation letter.

As it turned out, this had been a letter that had been provided to one of her staff as a request to allow the Healthy Heart Institute to go to Sunland Park and Lauderdale Manors, where a Mrs. Carlson's Keenagers group was seen by them. I indicated at the time Ms. McAllister called me that I would do some further checking to see whether or not, in fact, they had ever been to any of the housing authority sites. We have a number of sites and house a large number of elderly people. I later on learned that, in fact, they had been out to two of our sites, one where we have an adult day care center at which, obviously, large numbers of seniors congregate, and to another housing site.

Ms. McAllister explained to me at the time of her phone call some of the things that Mrs. Carlson has told you here today. It was beginning to appear from Suzanne McAllister's comments to me that there was some type of a problem with this Healthy Heart company. Once I began investigating with our staff and learned that, in fact, the same type of procedure had occurred on our sites, I became extremely concerned that this group was still operating in south Florida.

It was very apparent to me at that point in time that, in fact, it was a scam of massive proportions. I requested one of my staff do some local investigating, calling the secretary of state, to make a determination about the corporate status, checking with the occupational licensing divisions of the county and the various municipalities in Broward County as to whether or not there were, in fact, in effect a current license for the Healthy Heart Institute or any of the several other companies, the names of which had begun to come to light.

Ms. McAllister and I also were reviewing the written data and realized that several of these companies, while using different telephone numbers, were, in fact, using the same post office box in Hollywood, a further indication to us that there, in fact, was quite a problem here. Ms. McAllister and I agreed that it probably was something that needed to be reported, but in the interest of fairness determined that, in fact, we should invite the principals of these organizations or of the Healthy Heart Institute, which seemed to be the umbrella organization, to come to speak with the Keenagers, and with her and some of her staff, and myself and some of my staff, to allow them the opportunity to provide an explanation for what had been going on.

We met on the 23d of January. I believe it was at Sunland Park. And this group of individuals who had promised to be there from Healthy Heart and some of the other organizations, in fact, did not appear. After numerous phone calls to digital beepers, to answering machines and the like by Ms. McAllister in an effort to locate them, we terminated the meeting. And at that point, I went back to my office and spoke with our executive director, William Lindsey, about this. We determined that, in fact, the problem was of a scope larger than the local police department or even the attorney general of the State of Florida, perhaps, had jurisdiction over because it involved Medicare; that in fact, it was Federal.

We worked very closely with Congressman Shaw and determined that we should contact him immediately because of the nature, the Federal nature, as well as his position on the Ways and Means Committee. Mr. Lindsey spoke with one of the staff people in Mr. Shaw's office the following day, who referred him to the Utilization Review of Blue Cross and Blue Shield. We waited to hear from them. We did not hear from them. Finally, after about a week—I take that back. I'm sorry. I believe that they did make one return phone call to Mr. Lindsey. He was out of the office.

The bottom line was they were unable to make the connection, and we finally did go back to Congressman Shaw's office. We were working at that time through one of his staff, Peggy Kiser, who indicated that she was beginning to hear from some of the Congressman's other constituents with some of the same concerns.

I would like to add a personal note to this that aside from being a taxpayer, the constituency that the housing authority serves by and large is greatly at risk. We're dealing with, by definition, people who qualify for public or other subsidized housing, are low income. They tend to have an educational level that is generally not adequate to be dealing with this type of bureaucracy. And I am quite sensitive to this in that my mother resides in one of our housing complexes, and I know the difficulty that she has negotiating the system.

And it was of great concern to me that the people in our housing complexes had also been seen by this group. And I felt that they seem to be making quite a clean sweep throughout south Florida. I know how difficult it is at times to get people in the position of those who reside at the housing authority, particularly low-income minorities, to partake of available health care. And I was extremely concerned that it was going to have a long-term detrimental effect, not only on the treasury, on the taxpayer, but also on the long-term health of these individuals. And that was one the reasons for my personal urgency in wanting to contact the Congressman.

[The prepared statement follows:]

STATEMENT OF SARAH DONNELLY
Before the Committee on Ways and Means
Subcommittee on Oversight
July 30, 1990

I am Sarah Donnelly, Special Projects Director for the Housing Authority of the City of Fort Lauderdale, Florida. On August 17, 1990, I was contacted by Suzanne McAllister, Community Programs Supervisor for the City of Fort Lauderdale Parks and Recreation Department. The purpose of the call was to inquire about the Housing Authority's relationship with a group calling itself the "Healthy Heart Program." Ms. McAllister advised that this group was using the Housing Authority as a reference in a solicitation letter.

Ms. McAllister stated that the Healthy Heart Program had recently done some cholesterol and blood pressure screenings for the Lauderdale Manors "Keenagers," a social club of elderly persons who meet at the Lauderdale Manors Recreation Center to participate in recreational activities directed by Ada Moore, also a City of Fort Lauderdale Parks and Recreation employee.

The "Keenagers" screenings were done on November 6, 1989, at the Lauderdale Manors Recreation Center. Subsequently, some of the "Keenagers" began receiving notices from Medicare (Explanation of Medicare Benefits) relative to payments made on their behalf for testing. Several of these individuals were concerned that they had been victims of a Medicare fraud scam. Aside from the enormous dollar amounts billed to Medicare, several of the seniors noted billings for "home services," which they emphatically deny ever having received. In fact, the "home services" were billed by different providers than the ones who had billed for the diagnostic x-rays and diagnostic lab tests, but with the same billing date.

Upon further investigation, the Housing Authority discovered that a company calling itself "Medical Options Management, Inc." had visited the Housing Authority's Adult Day Care Center last July and performed screenings there. The Adult Day Care Center is located at 100 SW 18 Avenue, Fort Lauderdale, Florida, on the premises of the Sunnyreach Acres Public Housing Project for the elderly.

A review of some of the Medicare notices (Explanation of Benefits) received by five (5) Adult Day Care and housing project participants reveals the same patterns as those received by the "Keenagers" clients: large dollar amounts billed to Medicare, multiple providers and charges for home services which the clients deny having received. Two new elements were discovered among this group of clients, however: 1) Omnisonics, Inc., one of the providers, is pursuing a balance due - the amount of which Medicare did not pay - against a client, and 2) AARP insurance made a co-insurance payment to Nutek Diagnost on behalf of another client. The total amount billed Medicare on behalf of five (5) individuals was $7,115.00.

The principals of Healthy Heart failed to attend a meeting on January 23, 1990, at Sunland Park Recreation Center. This meeting was scheduled by Suzanne McAllister and was to have been an opportunity for a Mr. Scherr and Dr. Barton to explain what was going on. Although Ms. McAllister tried both their beeper numbers and their telephone listings, there was no response.

On January 24, 1990, Suzanne McAllister, Community Programs Supervisor, and Steve Person, Ms. McAllister's supervisor, met with me. We discussed that this scam appeared to be one of increasing proportions and that because of the federal nature of the apparent fraud, that it was not a matter for just the local police department to handle. Sarah Donnelly and William H. Lindsey, Executive Director of the Housing Authority of the City of Fort Lauderdale, Florida, discussed this matter previously and determined that unless some very satisfactory responses were forthcoming from the Healthy Heart people, we should contact Congressman E. Clay Shaw to let him know what we had learned. We felt also that it was important that Congressman Shaw be informed because of his position on the House Ways and Means Committee. Given that our earliest indications were that hundreds of thousands of dollars might be involved, we were particularly anxious to move quickly.

City staff decided that they would be notifying the City attorney, Dennis Lyles. They agreed that the Housing Authority should contact Congressman Shaw and stated that they could cooperate in all ways possible with any investigation which the Congressman decided to undertake.

William H. Lindsey and I met in Congressman Shaw's office on February 1, 1990, at which time we briefed the Congressman and his staff, Peggy Kiser and Dorothy Pickel, on the events surrounding our suspicions that a massive Medicare scam was going on in the South Florida area.

EXECUTIVE SUMMARY

A group of individuals, operating under a variety of company names including Healthy Heart Program, General Imagin, Omnisonics, Inc., Medical Options Management, Inc., Nutek Diagnost, Care Med, Central Med Ct., and others has been very active in Broward County, perhaps for at least a year, in providing cholesterol and blood pressure screenings to low income elderly.

These initial screenings, which are offered at little or no cost to the individuals, may be the first steps in a very lucrative and widespread Medicare fraud scam. The initial screenings are followed up (apparently only on Medicare eligible individuals and not on those with HMO coverage) by an extensive series of "diagnostic x-rays", non-invasive "Diagnostic lab tests" and supposedly "home services."

Follow-up of the initial screening with these additional tests usually occurs on the same day or shortly thereafter. The elderly recipients of these services are told that Medicare will be billed directly, that there will be no charge to them personally and that the results will be forwarded to their primary care physicians.

A preliminary investigation was undertaken by the Housing Authority when it was learned that one of the companies, the Healthy Heart Program, was using (without authorization) the Housing Authority's name in a solicitation letter. Furthermore, there are inaccuracies and false representations in this solicitation letter (Exhibit 1).

The findings of the Housing Authority's cursory investigation are as follows:

1. These companies are billing Medicare for work which some of the elderly state was never done, specifically, home services.

2. The services which were performed - and some of the recipients doubt that the diagnostic x-rays and lab tests were real - were done, not in a hospital, clinic or doctor's office, but with portable, mobile equipment which is taken by the companies to senior centers, adult day care centers, housing projects and other sites where large numbers of low income elderly may be found.

3. Thousands of dollars are being billed to Medicare by these companies for tests which may not have been performed, or if they were performed, which may not have been necessary.

4. The promised follow-up transmittal of the test results to the participants' primary care physicians has not been done among any individuals with whom we spoke.

5. Of the multiple providers, none has an occupational license in Broward or Dade Counties and only one, Omnisonics, Inc. is registered with Florida's Secretary of State, Corporations Division.

6. The principals of several of the companies have failed to appear at a scheduled meeting to explain the billings and the company policies and procedures. They no longer return telephone calls.

Chairman **Pickle**. Let me ask you, to all of you: Why did you not go to your own doctor for these kinds of examinations or talk to him or her about the screening? Did any of you talk to your own doctor ahead of time? Ms. Carlson?

Ms. **Carlson**. Not ahead of time. Since it was advocated that these would be free, and they promised that they would send the results of the testing to our doctors, so hopefully—I had an internist and also the gynecologist. And they were supposed—they had you to list your doctors and their addresses, and as a result of the testing, they were supposed to send that to the doctors.

Chairman **Pickle**. Well, it would seem the normal thing to do if they tell you to go take these tests, and it looked to be a reputable group, at no cost. I suppose you would not then call your doctor ahead of time. But none of you did talk to your own physician until after it was over with.

Ms. **Carlson**. Yes. After the screening, we talked and I checked with my doctors to see if they had received any results from this group, and they had not.

Chairman **Pickle**. Did any of you write to Blue Cross or to Blue Shield about these tests?

Ms. **Carlson**. I did.

Chairman **Pickle**. You did.

Ms. **Carlson**. I called first from a number that was listed in case you have problems, and the person on the telephone gave me the address of this utilization place and the address of the Blue Cross and Blue Shield. I wrote them, but I did not receive any answers. The only thing I received was bills that they had paid to this group.

Chairman **Pickle**. All right, thank you. Now, Mr. Shaw, do you have any questions of this panel?

Mr. **Shaw**. I have just a comment. We have heard the name of Dr. Barton several times. Dr. Barton, I believe, is Dr. Alan Barton Nachamie. I believe that reporter, Bob Knotts, from the Fort Lauderdale News Sun Sentinel did some research on him and found that this person has, in fact, served some time. I would certainly assume that he is not licensed to practice in the State of Florida.

I think this is something that we should also look into. When you take all these people going around referring to themselves as doctors, there may very well be some infractions of State law as well as Federal law as to holding themselves out to be a doctor when they are indeed not licensed in the State of Florida. I would guess that the fellow's name that I just mentioned was probably not licensed anywhere after having served his time and gotten into problems in—I believe it was in New York. Bob, is that correct?

Voice. Yes.

Mr. **Shaw**. Is my information correct on that? Incidentally, I might just point out that Bob has done an excellent job of research and general background in this particular area of Medicare fraud, and has been quite a resource in his reporting. Dr. du Pré, you are a medical doctor, yourself. Are you not?

Ms. **du Pré**. No.

Mr. **Shaw**. You are a doctor of what?

Ms. **du Pré**. Public administration.

Mr. **Shaw**. Oh, doctor of public administration. I see. Can you describe the machinery that was set up, or was it too much in the process of being packed up at the time?

Ms. **du Pré**. Yes. I only heard about it falling over, actually. I didn't see it. I didn't see the machinery the first day. The second day, I didn't really pay attention. I think Ms. Carlson gave a good description of what it looked like.

Mr. **Shaw**. Did anybody seem to be disturbed that this delicate medical equipment was being rolled over on the floor?

Ms. **du Pré**. Well, the staff at the Broward Center for the Blind thought it was rather shocking. When I confronted Roni Hill about it, she didn't seem to be that concerned. She said, "Oh, that stuff is pretty tough." I mean maybe it's tough, but I would think it would need to be recalibrated after taking a spill on the floor.

Mr. **Shaw**. Ms. Throckmorton and Ms. Carlson, could you all explain to us and describe the type of equipment? What did this equipment look like? Mary, I know I have talked to you about it, and it is just a bunch of blinking lights and things whirling around, and it is sort of something that you would see in Star Wars rather than in a medical office.

Ms. **Carlson**. Right. It was about the size of a TV set; I would say approximately 24 inches in length—now this is approximate—and I say about 10 or 12 inches on the other side. And all you could see was these round things looking like a movie machine or something on the screen as they were testing.

Mr. **Shaw**. Was this the same type of equipment?

Ms. **Throckmorton**. Well, actually it had a scope that showed the blips and audibly had the heartbeat, as well as the surge of the blood. But it showed on the screen as the blood surged through the particular areas that they were using their microphone on at the time. At times when there seemed to be any kind of slowdown of the flow of the blood, they would stop and make a notation on the tape as to a possible problem area. And it looked like a very sophisticated piece of equipment that would record your blood flow and heart flow, and it looked very legitimate. And they did remove a tape from it that would indicate that there was a background of information to go for analysis.

Mr. **Shaw**. I am particularly concerned about one of the points that you brought up in your testimony with regard to one of the residents who did have massive heart problems following this so-called test that said that her arteries were pretty clean, and of course, this certainly was not the case and they were badly clogged at the time. So this person was left with the false impression that she was quite healthy and probably was going to regulate her life accordingly, which might very well have brought on the massive heart attack.

So these people not only are defrauding the Federal Government, but they may be killing some of our people who rely upon their testing, which does not appear to be worth the paper it is written on, if, indeed, it ever gets written on any paper other than a bill to Medicare.

Ms. **Throckmorton**. This lady is a person who does not go to the doctor regularly, and she relied upon this man telling her that the heart arteries all looked good and did not follow up on it in any way. So the test, in most cases, have been absolutely money wasted because most people did not follow up by even giving them to their doctors or doing anything further pertaining to the tests. It's just money down the drain.

Mr. **Shaw**. Mr. Chairman, I would like to congratulate and tell you how proud I am to have these four ladies as my constituents; for them to have come forward the way that they have and not just simply shrugging this off, but actually pursuing it to the extent of bringing it to my office and talking to me about it, bringing it to the office of other Federal agencies, and also the Blue Cross and Blue Shield in order to try to bring some of this fraud under control. I think they are certainly to be congratulated tremendously for their efforts and public-service mindedness with regard to this whole matter.

Chairman **Pickle**. I add my commendations to each one of you, too, because if you had not asked normal questions, and been inquisitive, and were determined to get facts and information, this scheme might have gone on and on. I think we have to assume that as ordinary people, you would not be suspicious of somebody who is going to come in and give you medical tests for free. You would naturally be interested about your cholesterol or your heart condition. It would be a normal thing to say, "Yes, we would be glad to have you come in."

And yet, you did not know anything about these people. They were not officially approved by anybody. You did not check with your city, your county, and you did not check with the doctor involved or your own doctor, which perhaps would be a normal procedure. But at least once you got involved in it, you became suspicious and you did not let it go unreported. You did report it to the proper authorities.

I am surprised that we did not get any response from the inspector general from your contacts and/or the Blue Shield. We are going to hear from the Blue Shield representative in the next panel. But I want to add my commendation to you, and add also that I appreciate the fact that you did go to Congressman Shaw's office. And it seems to me that Congressman Shaw got some action for you, and got some people down here and got some investigations underway.

I think it is not appropriate for Mr. Shaw or I, either one, to say that the legal system is working too slowly. But it does bother me that all this took place some 6 or 8 months ago, and I do not know whether you are any further along in trying to get some indictments than you were the day you started. I am told that it is complicated, and I accept that. It is also embarrassingly slow because if these people are "crooks," as it would appear on the surface, then somebody ought to find them, or put them in jail.

This is the same thing that is happening all over the United States. So it is very important that you did report this to Mr. Shaw and to the other organizations. And that is why we wanted to come here, to hear firsthand what did happen to you in your case. So your testimony has been very helpful to us, and I personally appreciate it. I think we are going to have other hearings across this country on this same subject. So I want to thank you. Now, do you have any other questions at this time, Mr. Shaw?

Mr. **Shaw**. No. I believe this lady on the left wants to add something.

Ms. **Donnelly**. Yes. I would like to add I was—one of your staff had asked me what I thought could be done to help prevent this in the future.

Mr. **Shaw**. Yes.

Ms. **Donnelly**. And one of the things that I was contemplating over the weekend was perhaps requiring these providers when they obtain a provider number to post some type of a performance bond, not unlike is done in the construction industry, sort of a malpractice guarantee to the Government, that if, in fact, they are performing unnecessary tasks or billing outside the parameters, their surety would have to come in. And my guess is if you have the private sector involved and investigating these people from the front end of it, that perhaps there would be a little bit less of this kind of thing because they would have the liability and not the taxpayer.

Chairman **Pickle**. That is a good suggestion, and we will pass that along. Obviously, several changes have got to be made. One, there has got to be more regulations of these kinds of laboratories. Second, we have got to have a better check when they do come into your own home or your own mobile park unit. We have also got to have better contact with your physician, who should not accept or sign automatically the permit for using durable equipment or for other services until we have some personal knowledge of it. And your suggestion may be one of those. We are trying to gather a lot of different approaches that we will make in our report. That is why we have come here. I thank you for the suggestion. Ms. Carlson.

Ms. **Carlson**. Yes. Is it possible that we could have Medicare submit a statement or some type of form to the individuals with these unusual groups coming in that they received this type of service, that they receive what they said they were giving before paying them. See, they went on and paid them the amount and quickly, much quicker than they did our regular doctors. They paid them quickly, and if you could have them to submit, when these unusual groups come in, some kind of form to send to the recipient stating that he received this service before paying it.

Chairman **Pickle**. But they pay first, and then if they have time later, they may look into it.

Ms. **Carlson**. If you——

Chairman **Pickle**. Because we have got a lot of money, and so we have got to make payment immediately.

Ms. **du Pré**. Well, actually I learned something from what you said, Ms. Carlson. The original idea was they were to come just to speak to our clients. And then it turned into a free cholesterol screening. If it is free, they should not need any Medicare numbers or any kind of numbers from our clients, and frankly, I think what I have learned from this is that in the future, if somebody wants to come and speak to us, we will just make sure that nobody gives any insurance numbers. Then they can't bill.

Mr. **Shaw**. Let me pursue that for just a moment because I know both of you signed forms which said that Medicare was going to pay the 80 percent and that you all were responsible for the other 20 percent. What did they do? At the same time you signed it, told you not to worry about it, that it was not going to be the case? Is that the way this was handled?

Ms. THROCKMORTON. Well, actually the contributory insurance would cover the other 20 percent.

Mr. SHAW. That was in your case.

Ms. THROCKMORTON. In my case.

Mr. SHAW. You wrote the name of the insurance company down on the form. I saw that.

Ms. THROCKMORTON. Yes. Very, very gullible.

Mr. SHAW. Were you in a similar situation?

Ms. CARLSON. I immediately called. I have AARP through Prudential, and after receiving these bills and getting the idea that it was fraud there, I immediately called them and asked them not to pay the percentage that they had received from Medicare so they never paid.

Mr. SHAW. You both signed the form feeling that if this were legitimate, that your insurance companies were going to pick up that 20 percent.

Ms. CARLSON. Right.

Mr. SHAW. What about people who did not have insurance coverage?

Ms. CARLSON. I don't think they even went further than the cholesterol testing unless they saw that you had Medicare. You had to sign your Medicare number on a sheet, a checklist. And I don't think that they even bothered those people. I think their——

Mr. SHAW. What I am trying to pursue here is the extra 20 percent that your insurance companies were picking up. People who had Medicare but did not have the insurance to close that gap of 20 percent, what were they told, or do you know?

Ms. CARLSON. Just on the letter, we just—they haven't sent us a bill owing that or concerning that extra amount.

Mr. SHAW. No. I know that. Dr. du Pré, did you have a response?

Ms. DU PRÉ. They told that if a person didn't have supplemental insurance that the organization, itself, out of its generosity would just eat that.

Chairman PICKLE. They did what?

Ms. DU PRÉ. Out of their generosity, they would just absorb that loss.

Mr. SHAW. Ms. Donnelly, I am sure that was the case because I know a lot of your people do not have any insurance other than the Medicare.

Ms. DONNELLY. Yes, sir, the same with the housing authority. And in addition to that, I think you did touch upon an area. The people that had HMO coverage at our adult day care center, the director indicated to the groups that came in that they could not discriminate and only take the Medicare people. If they were going to be doing any kind of this free testing, they had to do everybody. In fact, the followup—it is my understanding that the followup with the extensive testing was only done with the Medicare recipients. And they were also told to not worry about the copayment, that that would not be collected. In fact, in one case they have been pursuing one of the patients for the copayment, which it is my understanding that that's what they are supposed to do. So they have been pursuing this individual. Knowing, however, the circumstances surrounding it, they have just been told to forget the copayment. They are not going to get it.

Chairman Pickle. Excuse me, Mr. Shaw.

Mr. Shaw. Yes, sir.

Chairman Pickle. You have got to admit that these mobile lab units have got the nerve of a brass monkey. They not only collect $1,000 or more from the services rendered for the lab tests, but they pursue you to get that copayment, to make you come up with that extra amount of money.

Ms. Donnelly. Yes, sir.

Chairman Pickle. Now, they have called you, in many instances, once or twice, to pay up your part either directly or through your supplemental. That takes a lot of nerve to do that. Perhaps they are doing it to show you that they want you to think they are really legitimate. It makes them look like they pursue it and get more money of their own. But the fact of it is that if we could act quickly, you could apprehend these kinds of groups. But unless groups do respond quickly, they can come in, make their hit, pursue you a little bit individually, and then they are gone.

Ms. Donnelly. I will say that the housing authority has in place now a screening procedure. Actually, we had it prior to the time that they came in. We just didn't realize. They contacted one of the staff people who thought what a great idea to let them come and serve the elderly, who may not be mobile, may be more isolated, might be inclined to not go if there were a charge. We do have a screening procedure. We do check references. We understand the value of mobile labs. As a matter of fact we're getting ready to let one come to our offices to screen tenants and staff for mammograms. Many of these people would not go and get one. However, we have checked their references. We've called around.

There will be a presentation prior to the lab's coming out to let the people know what they need in order for their insurance to cover it, if their insurance will cover it. There is going to be plenty of information to the people before these folks ever do any testing.

Chairman Pickle. Well, I want to thank this panel again for your testimony. Let this be a clarion call to people in this community, to others across this State and to the Nation at large that there are groups out there that want to get their hands on Medicare funds, and they are doing just that. We have got to stop this kind of ripoff. So I thank you very much for your testimony.

Mr. Shaw. Mr. Chairman.

Chairman Pickle. Mr. Shaw.

Mr. Shaw. One thing that might be helpful here: All of these people—this one happens to be Ms. Carlson's but we have got Ms. Throckmorton's, and we have got others that have submitted to us the explanation of Medicare benefits. Now that is sent out to them by Medicare. Perhaps it would be helpful if we would require the physician to send a copy of whatever they send in, their claim form, to Medicare at the time they are making the claim form, and give the people who will receive the treatment an opportunity to object before payment is made or certainly let the physician know or the laboratory or wherever it is know that the patient is going to be looking at the same thing that is submitted to Medicare in the form of a claim.

That may be very helpful, and I do not think that would be asking too much of the health care provider to provide that form so you will know exactly what it is that they are claiming.

Ms. CARLSON. Excuse me. That's exactly what I was saying, and send a form to the individual with the service——

Chairman PICKLE. Before payment.

Ms. CARLSON. Before payment, and let them sign the form saying that they have received the service before paying them.

Mr. SHAW. Or maybe just an explanation if you question any of the provisions provided here, please contact somebody so that those things could be flagged and people take a look at them.

Ms. CARLSON. Right.

Ms. THROCKMORTON. On our opening paper that was given to us, it said—the one that we signed that was our approval—it said that the charges could be, I believe it was like $150 up to $800. Well, now I think over $800 was about the lowest of any of the charges that were sent to Medicare. So that was a fallacy right from the start.

Mr. SHAW. Also, you get in trouble when you start talking about these letters because one of you all testified as to the payments being resubmitted. Well, that is called fragmentation. When the big bill is not accepted, then they send a bunch of little bills, and then they get parts and parcels of them paid off, which is not good. I think one of the best lines of defense we have, Jake, is just that the people who are receiving the benefits of Medicare know exactly what it is that is being billed, because there are a lot of people out there that are just like these two ladies that would certainly come forward and stop some of this nonsense, because they are the best indicator of what happens.

You know, quite frankly, when you receive something like this 2 or 3 months later, you are trying to remember what they did to you and it is not really that fresh in your mind anyway. But you can better believe that the doctors and laboratories, the legitimate ones, are certainly getting those bills out as quickly as they can because it just makes good sense from a business standpoint to do so.

Ms. THROCKMORTON. My doctor said he wished that he was paid as expediently by Medicare as this Omnisonics was.

Chairman PICKLE. Well, it is obvious, I think, to all of us that we have got to make some big changes and we have got to do them quickly. If the public ever really understands that an unauthorized group can come in to one of these residential units, make an examination, prick your finger, ask you a couple of questions, and then bill Medicare $1,000 without having any evidence that a test was done, like a report either from you or the physician, and Medicare just shells it out, there is going to be a rebellion in this country. These schemes can undermine or destroy Medicare. And we must do a better job.

Again, I want to thank you very much for your testimony. It has been very helpful, and we appreciate your coming.

Ms. THROCKMORTON. Thank you for allowing us to come.

Chairman PICKLE. Now we have come to the last panel, and a very important panel. We will have a lot of questions. We ask Mr. John Wachtel if you will come forward, sir. Mr. Wachtel is the manager of Medicare Part B Utilization Review, representing the Blue Cross and the Blue Shield of Florida.

Mr. Wachtel, I think because your testimony is so important, I am going to ask that you just start with your testimony and go right through with us completely rather than submit it for the record. It will all be included, but I would like for you to walk through this with us.

Mr. WACHTEL. Yes, sir. Thank you.

Chairman PICKLE. Is that agreeable to you?

Mr. WACHTEL. Yes, sir. I have testimony to submit for the record.

Chairman PICKLE. All right, if you will do that, sir. I am sorry. We thank you for coming, and we thank you for waiting. This is Mr. John Wachtel. If you will proceed, sir.

STATEMENT OF JOHN WACHTEL, MANAGER, PART B UTILIZATION REVIEW, BLUE CROSS AND BLUE SHIELD OF FLORIDA

Mr. WACHTEL. Yes, sir. Thank you. Mr. Chairman, Mr. Shaw, I'm John Wachtel, manager of the Medicare Part B Utilization Review Department at Blue Cross and Blue Shield of Florida. Thank you for asking me to be here today to talk to you about Florida Medicare's role in safeguarding the Medicare program from fraud and abuse. In particular, I would like to thank Congressman Shaw and members of his staff for inviting us to participate in this hearing, but also for their ongoing interest, support, and cooperation with our fraud and abuse activities, and our overall administration of the Medicare program.

As I have explained, I have submitted formal testimony for the record. Blue Cross and Blue Shield of Florida has administered the Medicare program in Florida since the program began in 1966. As one of the country's largest Medicare part B contractors, we will process in 1990 over 37 million claims, and we will pay more than $3 billion for health services to Medicare beneficiaries.

One of the most critical roles that we have as a contractor is to protect the Medicare program and the senior citizens of this State from fraud and abuse. Contrary to the testimony you heard earlier, fraud is a priority issue with Florida Medicare. In fact, 26 percent of all of the referrals to the Office of the Inspector General involve independent physiological labs, and 21 percent of all the referrals outstanding at this time involve the TENS unit issue.

Chairman PICKLE. Mr. Wachtel, we do not question your organization's commitment to provide the best medical service possible. I do not think Mr. Shaw or I either one question that. In your testimony you did say, though, that we, Blue Cross and Blue Shield, "earn no profit from our Medicare contract, as the program only reimburses budgeted costs." I need to understand that. You say you, Blue Cross, earn no profit from these contracts or these services.

Mr. WACHTEL. Yes, sir.

Chairman PICKLE. How is that possible?

Mr. WACHTEL. That's a fact. We are reimbursed based on a cost-per-claim basis. In other words, our budget each year is developed by projecting the number of claims that we will receive during the calendar year. These estimates are corroborated by the Health

Care Financing Administration, and a certain amount of money per claim is allocated for the program to the Florida carrier. And that's how our budget is developed.

Chairman PICKLE. I do not want to belabor this point because we can naturally look into that further, but you are reimbursed as an organization based on the number of claims submitted to your organization.

Mr. WACHTEL. Our administrative costs are reimbursed based on the number of claims that we processed at a certain——

Chairman PICKLE. You are paid, then, on the volume of claims.

Mr. WACHTEL. Yes, sir, that's correct

Chairman PICKLE. Nationally?

Mr. WACHTEL. No, sir.

Mr. SHAW. Is that based on the claims submitted or the claims approved?

Mr. WACHTEL. No, sir. It's based on the claims submitted to Florida.

Chairman PICKLE. You are talking about this State, but nationally, that is true all over.

Mr. WACHTEL. Yes, sir. It works the same throughout the nation.

Chairman PICKLE. Well then, you say here—and I don't want to belabor this, but I think it is something I want to look into as committee representative. You said that you handle more than 37 million claims. Is that annually?

Mr. WACHTEL. This year in 1990, we expect to process——

Chairman PICKLE. You paid out $3 billion.

Mr. WACHTEL. We expect to do that this year. Yes, sir.

Chairman PICKLE. Now, somewhere in there Blue Cross and Blue Shield has got to get paid for what they do, and if you just break even for your services, why are you in existence?

Mr. WACHTEL. We have a very strong commitment, Mr. Pickle, to the beneficiaries of the State of Florida and to the health care system.

Chairman PICKLE. I understand that, but you do that, and that commitment means you are going to render all this service, handle 37 million cases but not make any profit on it.

Mr. WACHTEL. Yes, sir. That's correct.

Chairman PICKLE. Well, I want to understand more about that.

Mr. SHAW. Is there not two Blue Cross and Blue Shield organizations, one nonprofit and one profit?

Mr. WACHTEL. No, sir. We are a mutual organization.

Mr. SHAW. Oh, OK.

Chairman PICKLE. Are you a 501(c)? What?

Mr. WACHTEL. You're getting into some legal terms, Mr. Pickle, that I'm unfamiliar with and are better answered by someone with more understanding of it.

Chairman PICKLE. We will want to know more about that, but you go ahead with your testimony, Mr. Wachtel.

Mr. WACHTEL. The Florida carrier has long been recognized as a leader in establishing safeguards to protect the Medicare program and its beneficiaries. During 1989, we recovered or saved more than $44 million from providers and suppliers in the State. For every dollar we spent on safeguard activities, we've saved the Federal Government and taxpayers $7. While we're proud of the savings we have achieved, in our opinion it's just the tip of the iceberg. Medicare carriers have a formidable task in curbing fraud and abuse. With 25 years of experience in the Medicare program, we have several——

Chairman PICKLE. Mr. Wachtel, where are your reading from now?

Mr. WACHTEL. I suspect, Mr. Pickle, you have my formal testimony before you.

Chairman PICKLE. Yes.

Mr. WACHTEL. I 'm reading from an opening statement.

Chairman PICKLE. I am trying to follow your statement, and I am not able to do that. Can you identify from your written statement where you are? Why do you not follow your statement submitted to us? If you do not have a copy of your statement you submitted, we will furnish you with a copy. Do you have it?

Mr. WACHTEL. I have found a copy.

Chairman PICKLE. I simply am trying to follow you as you make your statement.

Mr. WACHTEL. The formal statement is a lot more comprehensive, and I think——

Chairman PICKLE. That is what we want to see, Mr. Wachtel.

Mr. WACHTEL. All right, sir.

Chairman PICKLE. I have it on page 1. You start off, "Our Program Integrity Unit," and that is on the first page. Would you like to start at that point?

Mr. WACHTEL. I certainly would. We have 17 people in our Program Integrity Unit, and receive approximately 5,000 to 6,000 complaints of fraud and abuse annually. The majority of those complaints involve abuse rather than fraud.

Chairman PICKLE. Is that Florida, or is that nationally?

Mr. WACHTEL. That's in Florida.

Chairman PICKLE. All right. Go ahead.

Mr. WACHTEL. Yes, sir. Abuse is defined as an incident or practice directly or indirectly resulting in unnecessary costs to the Medicare program in improper Medicare reimbursement, or in reimbursement for services that fail to meet professionally recognized standards of care or are not medically necessary. But the most common abuse comes from the overordering of tests and supplies, known as overutilization.

However, abuse comes in a number of different forms, including billing the Medicare program excessive charges for services or supplies; billing the Medicare program for services—billing more than what is charged non-Medicare patients for the same service or supply; billing Medicare for services or supplies not medically needed by the patient; and breaches of the assignment or participation contracts, which result in beneficiaries being billed more for services than they should be.

Chairman PICKLE. Well now, Mr. Wachtel, this seems to be like in those three instances when you say there is some abuse, it would appear to me that that is just outright fraud. Would you agree?

Mr. WACHTEL. Fraud is actually a different animal. Abuse results in overpayments. Fraud is characterized, in our view, as for services not provided but billed for. They are first cousins, I would say, but they are different and they are handled differently.

Chairman **Pickle**. Is that the trouble we are having here in this case, trying to decide what is abuse and what is fraud?

Mr. **Wachtel**. No, sir. I don't think there is any trouble distinguishing which is abuse and which is fraud. I would say that working up a case of abuse and working up a case of fraud are very time-consuming and in many cases, in lengthy processes because you have to have all the i's dotted and all the t's crossed before you can pursue it.

Chairman **Pickle**. All right.

Mr. **Wachtel**. Fraud is the intentional deception and misrepresentation knowingly made by an individual to falsely gain some unauthorized benefit for himself or another person. Fraud in the Medicare program comes in a number of forms, some of those being billing for services or supplies that were not provided, falsely representing the nature of services rendered, filing claims for specifically noncovered services as if they were covered services, soliciting, offering or receiving a kickback, bribe, or rebate.

Chairman **Pickle**. Now, were all of those not, in your own judgment, all those four elements present in this Fort Lauderdale screening for cholesterol? Would it not appear to be?

Mr. **Wachtel**. Yes, sir. I think that is a clear case of fraud.

Chairman **Pickle**. Thank you.

Mr. **Wachtel**. In fighting fraud and abuse in the Medicare program we have three main roles: auditing and reviewing, collecting overpayments, and working to correct the provider practices that result in abuse of Medicare funds. For the purpose of today's hearing, however, I would like to concentrate on one area, and that is audits and reviews.

Medicare review activities assure that payments made are made only for services that are medically necessary, appropriate and covered by the program. For example, a person who receives a chest x ray but comes in to see a physician for a sprained ankle, the chest x ray would not be medically necessary for that, and we would characterize that as an abuse of the program. To perform these operations, prepayment review of claims is conducted based on national and local standards of what may be medically necessary. Screens in the computer system automatically suspend claims for services that fall outside of these practice standards.

Postpayment audits are also performed to identify patterns of over-ordering of tests, overutilization as we mentioned earlier. And through these pre- and post-payment efforts, we recovered, as I had explained earlier, more than $44 million from physicians and suppliers in 1989. Our utilization review department initiates audits and reviews of health care providers from information obtained from three sources primarily: our internal review of claims; from complaints from beneficiaries or providers; or from directions from agencies of the Federal Government, such as the Office of the Inspector General, the Health Care Financing Administration, and in some cases the Federal Bureau of Investigation.

Chairman **Pickle**. Pardon me for interrupting, but I am just trying to—you did recover some $44 million during 1989——

Mr. **Wachtel**. Yes, sir.

Chairman **Pickle** [continuing]. From either physicians, or practitioners, or organizations, or groups in the Medicare program.

Mr. WACHTEL. That's correct.

Chairman PICKLE. Now, that is not just from fraud. It could not be from fraud—or abuse. Most of it is from abuse?

Mr. WACHTEL. Yes, sir. That's correct.

Chairman PICKLE. Can you tell me the percentage of this amount of money?

Mr. WACHTEL. I could tell you that 75 percent of all of the work that we do involves abuse rather than fraud, and the other 25 percent is fraud. Primarily, the Office of the Inspector General pursues fraud issues once we have identified and ruled out everything that we can to determine that there is not an error on the face of the evidence.

Chairman PICKLE. On the face of it, it would seem to me that if you have actually recovered some $44 million this past year, there is a lot of abuse going on.

Mr. WACHTEL. Yes, sir. We are only skimming the surface.

Chairman PICKLE. All right. Go right ahead.

Mr. WACHTEL. When a complaint alleging fraud and abuse is received, we make every effort to rule out a billing error or patient misunderstanding. And after making these checks if fraud or abuse is confirmed, further action is taken. Cases involving documented evidence of fraud are referred to the Office of the Inspector General, and thereafter our role becomes a support role. After additional research, the case is considered for civil or criminal prosecution by the OIG, and we are often called to testify in those cases.

In cases of abuse, we recover inappropriate payments, then work to educate the provider through peer review and other activities, through warning letters, as well. Blue Cross and Blue Shield was one of the first carriers and is still one of the few that works in partnership with organized medicine in peer review. This is a committee type meeting of physicians who meet with their peers to understand their practice patterns and where they disagree, and have reservations about the frequency of services that are being provided, counsel the physician.

Chairman PICKLE. In this instance of the screening of cholesterol tests, was that reported to you, and did you then turn that over to the physician peer review committee here in this county, and they reviewed it?

Mr. WACHTEL. No, sir. This is not the type of review that the physician committee would do.

Chairman PICKLE. Who does that review then?

Mr. WACHTEL. It is done by us, by Medicare, and by the Office of the Inspector General.

Chairman PICKLE. These people who testified this morning reported that to the inspector general and to Blue Cross and Blue Shield, and they testified that they never heard from you.

Mr. WACHTEL. I, in particular, before coming down looked at the file on Mary Carlson, who testified previously. And we did find that there were overpayments made to General Imaging, the corporation that did the diagnostic testing. This was brought to our attention by Congressman Shaw in February, and in April, I believe, we requested a refund after not being able to get cooperation from General Imaging in terms of supplying medical information to us. We requested a refund.

Chairman PICKLE. You said there were some overpayments, but let me back you up. Why did you pay this General Imaging to begin with?

Mr. WACHTEL. We like to think when providers submit claims to us that they are legitimate claims.

Chairman PICKLE. Why? How do you know they are legitimate claims?

Mr. WACHTEL. Absent information to the contrary, we make the assumption that claims are legitimate, that providers are trying to do the right thing. When we find out that they are not, we flag these providers in our system.

Chairman PICKLE. Mr. Wachtel, I am not trying to be negative in my questioning, but I am trying to ascertain on what basis do you assume that when you get a billing from some organization with a medical name to it that they are legitimate and proper, and you should pay them. Is there any way that you can have a check made that you would have some feeling, or do you just accept anybody that sends you a statement?

Mr. WACHTEL. Providers and suppliers must have provider numbers, or supplier numbers in this case.

Chairman PICKLE. That is about as easy as getting a Social Security number.

Mr. WACHTEL. It's not much more difficult than that provided they have a business number. I have to agree with you.

Chairman PICKLE. Well, anyway, I am just trying to bring out these points.

Mr. SHAW. Let me bring up another point. I want to talk about Omnisonics right now for a moment. Is it not true that your people met with them and their attorneys and worked out some type of a deal where they can get back into business under another name with a new provider number?

Mr. WACHTEL. They are in business under another name.

Chairman PICKLE. In Florida?

Mr. WACHTEL. Yes, sir, in Florida.

Chairman PICKLE. What is the name now?

Mr. WACHTEL. The name now is RX Sonics.

Chairman PICKLE. RX Sonics?

Mr. WACHTEL. RX Sonics.

Chairman PICKLE. RX Sonics.

Mr. WACHTEL. Like the abbreviation for a prescription.

Mr. SHAW. Yes, I am sure that is it.

Mr. WACHTEL. We have had them under scrutiny and we have scrutinized for a period of time 100 percent of their claims.

Mr. SHAW. But is this not somewhat of a deal that you worked out, and is this not something that just goes on like for 60 days?

Mr. WACHTEL. It was there for a period of time, and we agreed after the 100 percent scrutiny of their claims to again review the adequacy of the information that they are submitting.

Mr. SHAW. Is there a written memorandum of this settlement?

Mr. WACHTEL. I don't know the answer to that, Congressman Shaw.

Mr. SHAW. If there is, would there be any problem with supplying that to this committee?

Mr. WACHTEL. I don't know why——

Mr. **Shaw**. I am very curious as to how you would let the same group go back, come up with a new name that is even more medical sounding, give them a new number, put them on probation for 60 days, and turn them loose. That does not make any sense to me. I am sorry, but it does not.

Mr. **Wachtel**. If there is a memorandum, we will be glad to furnish it to you.

Chairman **Pickle**. I do not know, Mr. Wachtel, if there is a memorandum. You furnish to this committee the people representing these organizations, what negotiations and the agreement of the settlement. This committee would like to see what arrangements were made.

Mr. **Wachtel**. I will be glad to find out that information for you.

Chairman **Pickle**. And submit it for the record.

Mr. **Wachtel**. Yes, sir.

Chairman **Pickle**. All right. Thank you.

Mr. **Wachtel**. Through our program safeguard practices, as I have explained, we save about $7 for every $1 we spend. We recognize that with additional resources, much more can be done. We worked very closely with Congressman Shaw's office in detecting fraud and abuse in several of these labs and continue to work pursuing these issues that he has brought before us.

As background on independent physiological laboratories, they perform certain diagnostic tests such as measuring the openness of arteries and veins, as well as the flow of blood through vessels. They also measure heart valve function and flow of blood through the heart. These laboratories are virtually unregulated at either Federal or State levels, and anyone with test equipment can obtain a business license to perform these very sophisticated, high-cost tests. Additionally, the Medicare program requires that a physician must initially certify that the lab staff was trained and the equipment is properly working.

Over the past 3 years, the number of such laboratories has increased by 56 percent, from 164 laboratories to 256 at the beginning of 1990. During 1989, 10 independent physiological laboratories were paid more than $500,000 each, and 3 reached as high as $1 million each during the year.

Chairman **Pickle**. Let me read that again. "During 1989, 10 independent physiological labs were paid more than $500,000 each, and 3 reached as high as $1 million in Medicare payments." In one year. And yet, you say they are not recognized on either a Federal or State basis; that almost anybody can go into the business and start performing these tests.

Mr. **Wachtel**. Yes, sir, that's correct. But the requirement——

Chairman **Pickle**. Is that still the condition now?

Mr. **Wachtel**. Yes, sir.

Mr. **Shaw**. But you say there is a requirement that the Medicare program requires a physician to initially certify the lab staff was trained and equipment was properly working.

Mr. **Wachtel**. That's correct.

Mr. **Shaw**. Is that in the Federal law or in the Federal regulations? Is that correct?

Mr. **Wachtel**. That I don't know, Mr. Shaw.

Mr. SHAW. You say the program requires it, so it has to be in one or the other. The question that I have, then, is do you have on file who the physician was that initially certified each one of these labs. Do you keep that as a permanent file?

Mr. WACHTEL. Yes, sir.

Mr. SHAW. Is there a permanent file, and is there any followup to certify these annually that the people are professionally trained to perform the tests that they allegedly perform?

Mr. WACHTEL. When the provider or supplier asks for a provider, we have to know that information. I do not believe that there is any followup.

Mr. SHAW. Will you supply this committee with the names of the physicians who certified the 10 independent labs with more than $500,000 and the 3 more than $1 million per year in Medicare payments?

Mr. WACHTEL. Yes, sir, I will.

Mr. SHAW. Is that just in Florida?

Mr. WACHTEL. Yes, sir.

Chairman PICKLE. All right. You are down to the bottom of that page now.

Mr. WACHTEL. Yes, sir. Although many of these labs provide legitimate, needed services, we know others provide highly questionable services lacking any real medical value to the patient and probably causing the patient undue concern. Several months ago, Congressman Shaw and I spoke about six laboratories that were providing free cholesterol screening for seniors in Broward County. Based on the information provided by the Congressman, we flagged these suppliers' claims for special review. And as a result of the intensified claims review, 36 percent of the billed claims were denied Medicare payment. And this number may go even higher as there are 47 percent of the claims that are still pending further information.

Medicare carriers have a formidable task in curbing fraud and abuse, and we offer for your consideration a number of suggestions to help carriers become more effective in conducting activities to reduce fraud and abuse.

First, we would urge you to increase the funding for program integrity safeguard activities. We believe that payment safeguard programs of Medicare intermediaries and carriers are among the best investments made by the Government and are essential to the sound management of its health care dollars. Funding these program safeguard activities has proven to be money well spent.

Nationally, contractors were paid about $358 million in 1989 to carry out these programs. According to a General Accounting Office report issued June 14, 1990, these program safeguards saved the Medicare program about $4 billion. Despite that success, payment safeguard funds decreased from $358 million in 1989 to $332 million in 1990. And as a result, the savings are expected to drop by nearly $500 million in 1990.

With Florida's large beneficiary and provider populations, we know that there is much more fraud and abuse going undetected. With additional funding, we could broaden the scope of our review efforts, including several special projects we know are needed but cannot undertake within our current budget. For example, electronic claims submission provides particular opportunities for fraudulent or abusive billing to Medicare. Currently our resources are inadequate to work widespread reviews of electronically submitted claims.

Chairman PICKLE. Are a lot of these claims being handled electronically now?

Mr. WACHTEL. Yes, sir, over half.

Chairman PICKLE. More and more are.

Mr. WACHTEL. Yes, sir.

Chairman PICKLE. And yet it is an open invitation——

Mr. WACHTEL. It is, indeed.

Chairman PICKLE [continuing]. For fraud in billing.

Mr. WACHTEL. Yes, sir.

Mr. SHAW. Of course, you do not have the Medicare beneficiary's signature. That is simply a claim that the physician has that signature on file. Is that not correct?

Mr. WACHTEL. That's correct. We also urge more funding for the Office of the Inspector General for more investigators. With more staff dedicated to the Medicare program, the OIG could develop and prosecute more Medicare fraud and abuse cases.

Second, physicians should be held more accountable for prescriptions they write for durable medical equipment, oxygen and other supplies. In many cases, prescriptions are solicited by suppliers. In other instances, physicians provide little or no followup to determine whether the oxygen or supplies prescribed improved the patient's condition. Medicare's monthly payments continue, however, for the life of the prescription. Last year we conducted a joint field survey with the Office of the Inspector General to determine whether oxygen was being used as prescribed. In a high percentage of cases, it was not being used at all or to the extent ordered by the physicians. In fact, one Medicare beneficiary came to the door smoking a cigar and was leaving to play golf. We are certainly delighted for his recovery, but we're concerned that Medicare was continuing to pay for the oxygen unit.

Chairman PICKLE. Did you continue his payment?

Mr. WACHTEL. No, sir. We did not.

Chairman PICKLE. Good.

Mr. WACHTEL. When we find medically unnecessary durable medical equipment or supplies being furnished to beneficiaries, the physician who authorized the equipment or supplies and initiated the abuse is held harmless financially. We believe abuse of Medicare payments for oxygen equipment and other supplies would drop dramatically if overpayments were recouped from the prescribing physician.

Third, there needs to be a certification process either at the State or Federal level for independent physiological laboratories. Currently anyone who has the equipment can deliver services prescribed by a physician. And any physician, even one working for the independent physiological laboratory, can prescribe the services.

Fourth, carriers should be funded for beneficiary education on detecting and reporting Medicare fraud and abuse. Although we work very closely with a number of beneficiary groups throughout the State and periodically issue educational materials to the media, we receive no funding for such activities. With funding, we could expand the education process to warn seniors against so-called free medical services and solicit their help in reporting potential fraud and abuse cases.

Implementing these recommendations will improve carriers' ability to take action to protect Medicare beneficiaries and program dollars, and we would appreciate your support. Blue Cross and Blue Shield of Florida thanks the subcommittee chairman and Mr. Shaw for allowing us to present our views on these important subjects. I would be happy to answer any questions which you have.

[The prepared statement follows:]

HEARING BEFORE THE OVERSIGHT SUBCOMMITTEE OF THE HOUSE WAYS & MEANS COMMITTEE

Testimony by John Wachtel
Manager, Medicare Part B Utilization Review
Blue Cross and Blue Shield of Florida

Fraud and Abuse in Medicare

Mr. Chairman and members of the subcommittee, I am John Wachtel, manager of the Medicare Part B Utilization Review Department at Blue Cross and Blue Shield of Florida. Thank you for asking me to be here today to talk with you about the Florida Medicare carrier's role in fraud and abuse activities.

Blue Cross and Blue Shield of Florida has administered Medicare in Florida since the program began in 1966. As one of the country's largest Medicare Part B contractors, this year we will process more than 37 million claims for medical services and supplies and will pay about $3 billion for health care services to Medicare beneficiaries.

We earn no profit from our Medicare contract, as the program only reimburses budgeted costs. But in keeping with our corporate mission, we have a deep-rooted commitment to providing the seniors in Florida with the best service that we can within the budget confines established by the government.

As the Part B carrier in Florida, we do much more than simply process claims, determine payments and respond to inquiries. Our job involves a number of activities to ensure appropriate payment to beneficiaries and providers as well as having in place payment safeguards to prevent fraud and abuse.

Today I want to tell you about how our safeguard programs work to protect seniors and the Medicare program from those who submit false or unnecessary Medicare claims for services to the elderly.

Our Program Integrity Unit, consisting of 17 staff members, receives between 5,000 and 6,000 complaints of alleged fraud and abuse annually. The majority of complaints we receive result from abuse, rather than fraud.

Abuse is defined as an incident or practice directly or indirectly resulting in unnecessary costs to the Medicare program, in improper Medicare reimbursement or in reimbursement for services that fail to meet professionally recognized standards of care or are not medically necessary. By far the most common abuse comes from delivering too much or too many medical services or supplies, known as "over-utilization."

Abuses occur in many other forms. A few examples include:

- billing Medicare excessive charges for services or supplies or billing Medicare more than what is charged non-Medicare patients for the same service or supply;
- billing Medicare for services or supplies not medically needed by the patient; and
- breaches of assignment agreements or participation contracts which result in beneficiaries being billed more than they should be.

Fraud, on the other hand, is the intentional deception or misrepresentation knowingly made by an individual to falsely gain some unauthorized benefit for himself or another person. Fraud in the Medicare program also takes many forms, the most common being:

- billing for services or supplies that were not provided;
- falsely representing the nature of services rendered;
- filing claims for specifically non-covered services as if they are covered services; and
- soliciting, offering or receiving a kickback, bribe or rebate.

In fighting fraud and abuse in the Medicare program, as a contractor Blue Cross and Blue Shield of Florida has three main roles: auditing and reviewing; collecting over-payments; and working to correct provider practices that result in abuse of Medicare funds. For the purpose of today's hearing, I would like to concentrate my remarks on the area of audits and reviews.

Medicare review activities assure that payments are made only for services that are medically necessary, appropriate and covered by the program. For example, we must be sure we do not pay for a chest x-ray for a patient who sought treatment for a sprained ankle. Although chest x-rays are covered by the Medicare program, a chest x-ray would not be medically necessary in this example.

To perform these operations, prepayment review of claims is conducted based on national and local standards of what may be medically necessary. "Screens" in the computer system automatically suspend claims for services that fall outside these practice standards.

Post-payment audits of claims are also performed to identify patterns of over-ordering of medical services, tests or supplies when compared with peer group norms. Through our pre- and post-payment efforts, we recovered more than $44 million from physicians and suppliers in the state during 1989.

Our Utilization Review Department initiates audits and reviews of health care providers from information obtained from three sources: our internal review of claims; complaints from beneficiaries or providers; or from directions from agencies of the federal government (such as the Office of the Inspector General).

When a complaint alleging fraud and abuse is received by our Utilization Review Department, we make every effort to first rule out a billing error or patient misunderstanding. After making those checks, the physician's or supplier's records are obtained. If fraud or abuse is confirmed, further action is taken.

Cases involving documented evidence of fraud are referred to the Office of the Inspector General. Thereafter, we provide a support role to the OIG. After additional research, the case is considered for civil or criminal prosecution.

In cases indicating abuse of the Medicare program, we recover inappropriate payments then work to educate the provider ourselves or through peer review. Blue Cross and Blue Shield of Florida was the first carrier and still one of the few to work in partnership with organized medicine in peer review. In peer review meetings, physicians are advised by their peers on more appropriate treatment or billing practices.

Though our program safeguard practices have proven their effectiveness by saving $7 for every dollar spent, we recognize much more could be done with additional resources. The potential savings are staggering, as demonstrated by current billing problems encountered with independent physiological laboratories. We have worked closely with Congressman Shaw's office in detecting fraud and abuse in several of these labs and appreciate the commitment and cooperation we have encountered from the Congressman's staff.

As background, independent physiological laboratories perform certain diagnostic tests such as measuring openness of arteries and veins as well as the flow of blood through blood vessels. Other studies test for heart valve function and flow of blood through the heart.

Because independent physiological laboratories are virtually unregulated at either federal or state levels, anyone with test equipment can obtain a business license to perform these very sophisticated, high cost tests. Additionally, the Medicare programs requires a physician must initially certify the lab's staff was trained and the equipment is properly working.

Over the past three years, we have seen the number of these laboratories increase by 56 percent, from 164 to 256 at the beginning of 1990. During 1989, 10 independent physiological labs were paid more than $500,000 each and three reached as high as a million dollars in Medicare payments for the year.

Although many of these labs provide legitimate, needed services, we know others provide highly questionable services, lacking any real medical value to the patient and probably causing the patient undue concern.

Several months ago Congressman Shaw and I spoke about six laboratories that were providing free cholesterol screening for seniors in Broward County. Based on the information provided by the Congressman, we flagged these suppliers' claims for special review. As a result of that intensified claims consideration, 36 percent of the billed claims were denied Medicare payment. This number may be even higher, as 47 percent of the claims required additional review to determine if payment was appropriate.

Medicare carriers have a formidable task in curbing fraud and abuse in the Medicare program. We offer for your consideration a number of suggestions to help carriers become more effective in conducting activities to reduce fraud and abuse:

1. First, we urge you to increase funding for program integrity safeguard activities. We believe the payment safeguard programs of Medicare intermediaries and carriers are among the best investments made by the government and are essential to the sound management of its health care dollars. Funding these program safeguard activities has proven to be money well spent.

   Nationally, contractors were paid about $358 million in 1989 to carry out these programs. According to a General Accounting Office report issued June 14, 1990, these program safeguards saved the Medicare program about $4 billion. Despite that success, payment safeguard funds decreased from $358 million in 1989 to $332 million in 1990. As a result, savings from safeguard programs are expected to drop nearly $500 million in 1990.

   With Florida's large beneficiary and provider populations, we know there is much more fraud and abuse going undetected. With additional funding, we could broaden the scope of our review efforts, including several special projects we know are needed but cannot undertake within our current budget. For example, electronic submission of claims provides particular opportunities for fraudulent or abusive billing to Medicare. Currently our resources are inadequate to work widespread reviews of electronically submitted claims.

   We also urge additional funding for the Office of the Inspector General for more investigators. With more staff dedicated to the Medicare program, the OIG would develop and prosecute more Medicare fraud and abuse cases.

2. Physicians should be held more accountable for the prescriptions they write for durable medical equipment, oxygen and other supplies. In many cases, the prescriptions are solicited by suppliers. In other instances, the physicians provide little or no follow-up to determine whether the oxygen or supplies prescribed improved the patient's condition. Medicare's monthly payments continue, however, for the life of the prescription. Last year, we conducted a joint field survey with the Office of the Inspector General to determine whether oxygen was being used as prescribed. In a high percentage of cases, it was not being used at all or to the extent ordered by the physicians. In fact, one Medicare beneficiary came to the door smoking a cigar and was leaving to play golf. We are delighted for his recovery but were concerned that Medicare was continuing to pay for the oxygen unit.

   When we find medically unnecessary durable medical equipment or supplies being furnished to beneficiaries, the physician who authorized the equipment or supplies, and initiated the abuse, is held harmless financially. We believe abuse of Medicare payments for oxygen equipment and other supplies would drop dramatically if overpayments were recouped from the prescribing physician.

3. There needs to be a certification process either at the state or federal level for independent physiological laboratories. Currently, anyone who has the equipment can deliver services prescribed by a physician; and any physician, even one working for the independent physiological laboratory, can prescribe lab services.

4. Carriers should be funded for beneficiary education on detecting and reporting Medicare fraud and abuse. Although we work very closely with a number of beneficiary groups throughout the state and periodically issue educational materials to the media, we receive no funding for such activities. With funding, we could expand the education to warn seniors against so-called free medical services and solicit their help in reporting potential fraud and abuse.

Implementing these recommendations will improve carriers' ability to take action to protect Medicare beneficiaries and program dollars. Blue Cross and Blue Shield of Florida thanks the Subcommittee Chairman and members for allowing us to share our views on this important subject.

Chairman PICKLE. I thank you for your testimony and your cooperation. With respect to these recommendations you made, they are good ones and we will pay close attention to them. We appreciate your suggestions because you are in the field, and you can give us better recommendations than anyone else. So I thank you for these suggestions.

Mr. WACHTEL. Yes, sir.

Chairman PICKLE. You want more funding for both the inspector general and for Blue Cross and Blue Shield. Have you asked for more funding in the Federal budget?

Mr. WACHTEL. We ask for funding every year that generally exceeds what the Health Care Financing Administration is willing to fund for us.

Chairman PICKLE. What does Health Care Financing tell you?

Mr. WACHTEL. They tell us that their funds are limited for distribution nationwide and that they set limits on the cost per claim that they are going to give us to administer the Medicare program.

Chairman PICKLE. Well, it is like the legal complexities they say of this screening. The budget problem on a Federal basis is very complicated, too.

Mr. WACHTEL. Yes, sir. I'm sure it is.

Chairman PICKLE. We are going through a nightmarish time right now trying to figure out how we can meet our obligations. But you actually are losing ground now. You are getting less money than you did get for these field inspectors and for these people who make these personal investigations. So this gets to be a big problem. It seems to me like we could argue that if you had these personnel, you would save money, we would make money.

Mr. WACHTEL. It would certainly indicate that from our historical performance, where we are saving about $7 for every $1 we spend.

Mr. SHAW. Mr. Chairman, it is interesting to note the mathematics of the testimony near the top of page 3 when Mr. Wachtel said that we spent $358 million in 1989 on program safeguard activities and $332 in 1990, and as a result we drop nearly a half a billion dollars in savings that we could have otherwise realized. So as I understand what you are saying, it is your opinion if we spent $26 million more, we would have saved $500 million.

Mr. WACHTEL. Yes, sir. Nationwide, that's the General Accounting Office report.

Mr. SHAW. I think we have to be very careful with the way we spend the Federal dollars, but if you are even one-third right, that would be a heck of a savings. Just looking up at the top of that page, when you talk about the claims that you looked at that we turned into you—and that was just a few of these labs—you say 36 percent have been denied, and you are holding up another 47 percent. That means that there is a possibility of up to 83 percent of these claims were not legitimate, 83 percent of the claims that were being submitted by these labs were not legitimate.

Mr. WACHTEL. There is certainly that potential.

Mr. SHAW. We need to do some intensified looking at some of these claims. There is no question about that.

Chairman PICKLE. Mr. Wachtel, back to our budgeting. You said that with additional funding, you would undertake "special fraud projects." Exactly what kind of fraud project do you have in mind?

Mr. WACHTEL. We have engaged over the last couple of years in 11 special projects that are broad in scope. They are generally single-issue type projects that are very broad in scope that encompass a number of physicians and suppliers. And through these 11 projects, we have identified over $4.5 million in overpayments, payments that never should have been made.

Chairman PICKLE. Would you identify for our committee these 11 projects by description so we might have a chance to review them?

Mr. WACHTEL. Yes, sir, I can do that.

Chairman PICKLE. All right. I thank you for it. Now you said that you, Blue Cross and Blue Shield, cannot process electronically submitted claims because it does provide special opportunities for fraud. I would like to give you some examples of why that is so, but let me ask you first, though: Were the cases that we are talking about today, were they filed electronically?

Mr. WACHTEL. I don't know the answer to that right off the top of my head.

Chairman PICKLE. Apparently, they were not, but you do not know.

Mr. WACHTEL. I don't know that.

Chairman PICKLE. All right. Now give me some kind of example just so I can understand it. How would it be easy for the system to be defrauded if you file a claim electronically?

Mr. WACHTEL. The claims come in electronically. There's never a piece of paper generated. No human hands touch it. It goes through all of the system checks to make sure that the salient information, the beneficiary's name, the beneficiary's health insurance claim number, is there; that the dates of service are on the form; that the procedure codes are there; that the pricing is there. And after it goes through pricing checks and some of the automated medical checks, that's it. The claim is gone, and a check is cut if there is any payment to be made.

We are able to process these claims. We are not able to audit these claims because we don't have the funding to go out in the field and do that.

Chairman PICKLE. The trend is to be making payments electronically. The trend is to include that with respect to payment of income taxes. They are beginning to handle those electronically. I guess we cannot assume that that will not also go into our billing process. But at this point the procedure we use, you say, is not adequate enough to prevent fraud, and that it is an open invitation for a lot of it.

Mr. WACHTEL. Yes, sir. We are caught in the middle of this issue with the Government telling us that we need to process claims within certain time frames; and at the same time, there are more and more claims that we need to be looking at on a manual basis.

Chairman PICKLE. Earlier this morning when Mr. Cottos testified, he said he was having some difficulty getting information from Blue Cross and Blue Shield. Is there any reason why you cannot give the inspector general the information he needs by the close of business say on a weekly basis?

Mr. WACHTEL. Yes, sir. Based on the volume of claims that we are getting from several field offices, that would be virtually impossible to do. We have, however, budgeted in our fiscal 1991 budget for staff solely responsible for responding to OIG requests for information. The issue that Mr. Cottos raised is certainly a valid one, and we make every effort to respond to it.

Chairman PICKLE. I notice that Mr. Cottos is still here. Will you submit to our committee some example of information that you need, that you have requested, and have not been able to get? For our own information, will you do that?

Mr. COTTOS. Yes, sir, I can.

Chairman PICKLE. Will you do that?

Mr. COTTOS. Yes, sir, I can.

Chairman PICKLE. Thank you.

[The information follows:]

DELAYED RECEIPT OF MEDICARE-PART B DOCUMENTATION FROM THE FLORIDA CARRIER, BLUE CROSS/BLUE SHIELD OF FLORIDA
JACKSONVILLE, FL
AS REQUESTED BY THE DEPARTMENT OF HHS OFFICE OF THE INSPECTOR GENERAL OFFICE OF INVESTIGATIONS.

SE#	TYPE OF DOCUMENT	DATE REQUESTED	RECEIPT DATE	REMARKS
89-00305-9	CLAIMS	12/18/89	NOT REC'D	
	CLAIMS	01/25/90	NOT REC'D	
	CLAIMS	02/26/90	NOT REC'D	
	CLAIMS	(REKEYED) 03/33/90	NOT REC'D	
89-00581-9	CLAIMS	04/20/90	NOT REC'D	
		(REKEYED) 06/19/90	NOT REC'D	
90-00289-9	CLAIMS	04/17/90	07/09/90 (PARTIAL)	SOME CLAIMS OUTSTANDING
	MED-180 (BENFICIARY HISTRY)	04/17/90	07/09/90	
89-00306-9	3 MED-185'S (PROVIDER HISTORY)	06/11/90	07/23/90 (PARTIAL)	SOME CLAIMS OUTSTANDING
	2 MED-186'S (SELECTED PROVIDER HISTORY)	06/11/90	07/23/90 (PARTIAL)	SOME CLAIMS OUTSTANDING
	CLAIMS	06/11/90	07/23/90 (PARTIAL)	SOME CLAIMS OUTSTANDING
	REORDER OF ABOVE	(REKEYED) 07/20/90		SOME CLAIMS OUTSTANDING
	REORDER OF ABOVE	07/25/90		SOME CLAIMS OUTSTANDING
89-00527-9	CLAIMS (40-50)	UNKNOWN	IN EXCESS OF 3 MONTHS	PARTIAL REC'D BUT INCOMPLETE
89-00562-9	CLAIMS	UNKNOWN	4-6 MONTHS TO COMPLETE	
90-00050-9	CLAIMS	UNKNOWN	EXCESS OF 3 MONTHS	

SE#	TYPE OF DOCUMENT	DATE REQUESTED	RECEIPT DATE	REMARKS
88-00648-9	PRESCRPTIONS/CLAIMS	1989	NOT REC'D	TAPES LOST-IRRETRIEVABLE
86-00350-9	CLAIMS	04/17/89	IN EXCESS OF 30 DAYS	
		04/21/89	IN EXCESS OF 30 DAYS	
		05/09/89	IN EXCESS OF 30 DAYS	
		07/25/89	IN EXCESS OF 30 DAYS	
86-00350-9	MED-186	05/09/89	10/02/89	
90-00265-9	MED-186	03/23/90	05/11/90	
88-00902-9	PRESCRPTIONS/CLAIMS	11/17/89	04/01/90	PRESCRIPTIONS ONLY-CLAIMS STILL OUTSTANDING
89-00719-9	UR-620 (PROVIDER HISTORY)	10/12/89	04/26/90	
	UR-4310 (PROVIDER HISTORY)	10/12/89	05/14/90	
89-00128-9	MED-186 (PROVIDER HISTORY)	05/04/89	11/07/89	
	MED-186	06/25/90	NOT REC'D	
	MED-186	06/27/90	NOT REC'D	
	MED-186	06/29/90	NOT REC'D	
	PRESCRIPTIONS	04/19/90	UNKNOWN	NOT YET IN FULL RECEIPT
89-00742-9	CLAIMS (10)	10/23/89	02/20/90 (PARTIAL)	7 RECEIVED
	CLAIMS (40)	11/20/89	02/20/90 (PARTIAL)	ALL NOW RECEIVED
	CLAIMS (90)	11/21/89	02/20/90	25 OUTSTANDING AS OF 02/20/90 -7 OUTSTANDING AS OF 3/19/90
	CLAIMS (87)	11/22/89	02/20/90	6 NOT RECEIVED AS OF 02/20/90

SE#	TYPE OF DOCUMENT	DATE REQUESTED	RECEIPT DATE	REMARKS
	CLAIMS (35)	11/22/89	02/20/90	23 OUTSTANDING AS OF 02/20/90
88-00828-9	CLAIMS (15)	03/14/89	05/12/89	
	PRESCRIPTIONS	03/14/89	05/12/89	
	MED-186	03/02/90	04/10/90	
88-00580-9	CLAIMS	08/24/89	10/25/89	
	CHECKS (30)	05/24/90	NOT REC'D TO DATE	
90-00452-9	UR-4310	01/88	06/88	
	MED-186	01/01/88	02/12/88	
	MED-186	04/15/90	06/20/90	
	CLAIMS	06/18/90	PARTIAL REC'D TO DATE	

SHOULD BE NOTED THAT IN ALL OF THE ABOVE REQUESTS, THE CARRIER IS SUPPOSED TO ABLE TO MAKE ALL OF THE ABOVE RECORDS AVAILABLE WITHIN 2-30 DAYS OF THE QUEST.

RTHER, DURING A CONTACT WITH AN OFFICIAL OF THE UTILIZATION REVIEW SECTION OF /BS OF FLORIDA, IT WAS DETERMINED THAT MOST OF THE MED REPORTS WERE UNAVAILABLE ROUGHOUT 1989 DUE TO COMPUTER PROBLEMS. THIS DELAY OBVIOUSLY DELAYED OUR ILITY TO IDENTIFY CLAIMS/PRESCRIPTIONS REQUIRED FOR THE INVESTIGATIONS TO OCEED ON A TIMELY BASIS.

Mr. **Shaw**. Could I interject here? Do you see any problems of giving them direct computer access to your files so that they do not even have to bother you about it?

Mr. **Wachtel**. I frankly don't see any problem with it. I think it would not completely resolve the situation because much of the information that they do request is for hard copies or originals of information that has been submitted to the carrier, and that information——

Mr. **Shaw**. Well, they may need that from an evidentiary standpoint once they go forward with a criminal or civil procedure. But I think from a standpoint of just an investigative point of view that they do not need those original documents. It will be actually down the line before they even have to come in and request those. It seems to me that it would cut down on your administrative overhead not having to fuss with them on it. Second, it would expedite their investigations so they do not have to sit around and wait for stuff. You know, it is very difficult to proceed with any type of law case if you have got to stop 2 or 3 months, and then you have to get back into the file, you have got to review it again. If the investigator could go right to a terminal, pick it up like that, then he does not have to spend another day getting back into the file when the information finally comes in and the investigation goes forward. An investigator, by the time the information comes in, has forgotten what he asked for if you are talking about 4 and 5 months. That just does not make any sense.

Mr. **Wachtel**. I'm not aware of any particular situation that takes 4 to 5 months, but I agree with your point.

Mr. **Shaw**. He testified to some that we are going to supply you with and we would like to know about. But even if it is a month, or even if it is a week, there is no sense—unless there is a reason why they cannot have direct access just to retrieve information from the file, I do not see why we should stand in their way. I think you probably agree with me. You certainly have not given any indication otherwise except for the fact that they may have to ask for additional information later to go forward from an evidentiary standpoint.

Mr. **Wachtel**. I am all for anything that can expedite their handling of these cases that need to be——

Mr. **Shaw**. Then your answer is yes, it is probably a good idea. Is that correct?

Mr. **Wachtel**. Yes, indeed.

Mr. **Shaw**. Good.

Chairman **Pickle**. Well, we are concerned about why it takes so long. Mr. Cottos testified that it takes too long, and by the examples he is going to give us, we will make some evaluation on them. But you recognize that time would be helpful, and we ought to have them quicker.

Mr. **Wachtel**. Certainly that's the case.

Chairman **Pickle**. Let me go back to some of the testimony we received this morning. In the case of free cholesterol testing scheme that was reported to Mr. Shaw that we talked about this morning, why did it take so long to uncover it?

Mr. **Wachtel**. We had uncovered a number of these schemes before I spoke to Congressman Shaw in February. As a matter of fact, we now have and had as early as sometime in 1988, 20 of these noninvasive diagnostic testing facilities on flag, and in fact a couple of those that were reported to me by Congressman Shaw were already under this increased claim scrutiny.

Chairman PICKLE. Do you have any estimate of how much money was wasted reimbursing labs for followup tests after free cholesterol screening by this Healthy Heart group.

Mr. WACHTEL. I can tell you that of the laboratories that we have identified thus far and had flagged in 1989, we paid them about $3.8 million, which is a significant amount of money.

Chairman PICKLE. $3.8 million paid to Healthy Heart?

Mr. WACHTEL. Not all of these were the Healthy Heart program.

Mr. SHAW. Healthy Heart was included in the list of lab certifications that I asked for, was it not?

Mr. WACHTEL. Yes.

Mr. SHAW. Do you flag the physician who initially certifies that a lab staff was trained and equipment was properly working once you find that one of the labs is, in fact, a scam and find a large number of fraudulent or abusive claims that are being filed? Do you go back and flag that this is the same physician in case he comes up and certifies another one? Are you finding that the same physician is certifying lab after lab after lab?

Mr. WACHTEL. We have not precisely followed that protocol, but what we have done is to identify the physicians who are authorizing the tests to be done. And where we see a pattern, we refer it to the inspector general's office, and we are gathering that information, and are referring it to them as part of their ongoing investigation.

Mr. SHAW. It would seem that the certifying physician should also be looked at very carefully, and with that I would go back and ask that with this Omnisonics and RX Sonics, is it the same physician. I guess RX Sonics had to be certified again. Who is the doctor who certified that, and is he the same one who—are we asking the same opinion from the doctor who got us in trouble in the first place?

Mr. WACHTEL. Our experience has been that these physicians, the ones that we have personally met with, the companies that have come to us because we have either slowed down or stopped their claims payments, are not physicians who are practicing physicians. They have a degree, but they are either retired or got out of the practice of medicine for whatever reason, and have sought other opportunities.

Mr. SHAW. Wait a minute. Then this Dr. Barton Nachamie, who is indeed a graduate of medical school, but is certainly not licensed to practice in the State of Florida and is a convicted felon, do you mean he can certify these labs?

Mr. WACHTEL. No, sir, he cannot. It's my understanding that he is a chiropractor.

Mr. SHAW. But if he were a medical doctor under the same circumstances, even though he might have been a convicted felon, he could certify one of these labs and you would have to take it as a certified lab.

Mr. WACHTEL. Only if he had a license to practice in Florida.

Mr. Shaw. Wait a minute. I thought you said all he had to have is a medical degree, that you did not have to be licensed to practice.

Mr. Wachtel. Well, they certainly have to be licensed.

Mr. Shaw. Oh, they have to be licensed——

Mr. Wachtel. Yes.

Mr. Shaw [continuing]. To practice in Florida, and they are the ones who certify these labs.

Mr. Wachtel. Yes, sir.

Chairman Pickle. Did that Dr. Nachamie certify this lab?

Mr. Wachtel. No, sir.

Chairman Pickle. Who did certify the lab?

Mr. Wachtel. I don't know the answer to that.

Chairman Pickle. Are any of the mobile labs that did submit questionable bills for followup tests in operation here today?

Mr. Wachtel. Yes, sir. They are in operation, but they are receiving very little, if any, payment.

Chairman Pickle. But they are in operation, and they are legal. Can you give us a list of those labs that you think are still in business now?

Mr. Wachtel. Yes, sir.

Chairman Pickle. All right. I would like to have it.

Mr. Shaw. Can these labs be decertified?

Mr. Wachtel. Well, they are not certified by the State or Federal Government.

Mr. Shaw. So once they have been certified by the physician and have a provider number, then no matter what they do, there is no way to get rid of them as long as they want to submit the tests. The only recourse you have is just to keep an eye on them. Is that correct?

Mr. Wachtel. Yes, sir. However, if they are——

Mr. Shaw. You cannot take their provider number away.

Mr. Wachtel. It can be done through cooperation with the Office of the Inspector General and the Health Care Financing Administration if there is strong suspicion of fraud.

Mr. Shaw. Have you taken any of these numbers away?

Mr. Wachtel. No, sir.

Mr. Shaw. So to your knowledge, they have never taken any of these provider numbers away, even to the convicted felon who you said is a chiropractor and that whole Healthy Heart conglomerate which seems to be creating so many of the problems right here in south Florida. They still have got their numbers and they can submit it under any of the numbers, I guess, or go get a new one, as they seem to be doing.

Mr. Wachtel. Mr. Nachamie and the Healthy Heart Program, which you had reported to me back in February, is not a provider in and of itself. It's a name that is given to, as far as I can tell, attract people to come.

Mr. Shaw. That is the come-on, and then they get one of these other groups to come in.

Mr. Wachtel. That's my understanding of it. Healthy Heart Program absolutely does not have a provider number of its own.

Mr. Shaw. Mrs. Throckmorton testified that one of the people in her mobile home may damn well have been killed by one of these guys by telling that lady that she had clear arteries and everything else. And then in May, she comes in with a heart attack.

Mr. WACHTEL. That's a very unfortunate situation.

Chairman PICKLE. Well, it is your statement that there are no standards of qualification for these labs to go into business.

Mr. WACHTEL. That's correct.

Chairman PICKLE. Should there be some sort of certification required?

Mr. WACHTEL. Yes, sir. I think that there needs to be some, at least at the State level, certification that the people who are operating the lab have appropriate qualifications to operate the equipment, that they are certified at least by the State and have passed some kind of training program to show their certification.

Chairman PICKLE. I think you stated earlier that at least there is a physician, a peer review committee that looks this type of laboratory over and reviews them every 6 months. Why do you do it only every 6 months? Why could that not be done regularly, or should it be done regularly?

Mr. WACHTEL. The peer review committees are reviewing physician services rather than supplier services.

Mr. SHAW. Who reviews the supplier services?

Mr. WACHTEL. There is no review mechanism in place for them.

Mr. SHAW. I understand, though, that there is a utilization review that is computed every 6 months.

Mr. WACHTEL. Yes, sir, that's correct.

Mr. SHAW. Why would you not do that more often? Because it seems like some of these things that are running up hundreds of thousands of dollars should pop right out of the computer so someone would go take a look at it and they see if they are setting up shop in mobile home facilities and recreational facilities, even in churches, that someone go take a look at it and see what they are doing.

Mr. WACHTEL. Six months is, based on the scope of the work that is involved, a very short period of time.

Mr. SHAW. But your experience has been that as soon as one of those is flagged that a new provider number is applied for and those same people you find probably a year down the line are popping up again because of your 6-month review. Is that not correct?

Mr. WACHTEL. Yes, sir. That's entirely possible.

Mr. SHAW. So do you not think it would be money well spent on reviewing these, maybe even on a monthly basis, particularly your larger providers?

Mr. WACHTEL. Yes, sir. Given the resources, we could certainly do that, and it would certainly be——

Mr. SHAW. How much would that cost?

Mr. WACHTEL. I haven't actually computed that. It costs about $25,000 for one person on an annual basis.

Mr. SHAW. Well, why do you not just put that one person all of the time just pulling them up and reviewing them. I cannot see with this age of computers that one person just to sort of be the watchdog on that would be any problem, and I do not think that the caseload would be any heavier to keep up with on a daily basis than it would be to do a massive update every 6 months. It appears to be that it would be much more cost-efficient and really would not be that much more expensive.

Mr. WACHTEL. It would seem that way——

Mr. SHAW. But you are talking to somebody who is computer illiterate. I do not understand computers, but to me, it just seems logical that to do it on a daily basis is no more burdensome than to start every 6 months taking up the backlog.

Mr. WACHTEL. We certainly recognize that there are areas where there need to be tighter controls.

Chairman PICKLE. Mr. Wachtel, I understand from your testimony that you say that you have got two main functions; that is, you have got the function of processing claims and the obligation of making payments. Now do you think that the HHS, in your opinion, pays sufficient attention to the safeguard activities, or do you think they are just primarily concerned with prompt payment?

Mr. WACHTEL. I think that their number 1 priority is to assure that the seniors across the country either are paid or have their Medicare services paid in a prompt fashion. That's certainly true. I think that the Health Care Financing Administration certainly recognizes that there are unscrupulous people who would take from the Medicare program inappropriately and fraudulently, and I think that they are bound by having to spread the administrative dollars very carefully so that every carrier can operate within the confines of the money that's allocated to the Health Care Financing Administration.

They do recognize that there is a need——

Chairman PICKLE. When you say they recognize, let me phrase it now in my term. As Members of Congress, we hear general rumors that when a carrier gets behind on their processing of claims that they just stop screening and they make those prompt payments, and that that is what HSS really wants them to do. Is that generally correct?

Mr. WACHTEL. I'm not sure what the process is when carriers get behind in making payments.

Chairman PICKLE. If you are handling some 37 million claims a year, you are always behind. Are you not? So it is a tendency to put emphasis on payment rather than screening an illegal claim. That is human nature. Would that not be generally correct?

Mr. WACHTEL. Yes, sir. That would be generally correct.

Chairman PICKLE. Because it is such a vast program, so much money involved, and so many people actually waiting for some reimbursement, the emphasis is to get those payments out whether they are proper claims or not, and then hope you can investigate them later.

Mr. WACHTEL. There is a great deal of emphasis on that. I would have to agree with you.

Mr. SHAW. Mr. Chairman, in that regard there was a big problem with claims processing backlogs here in Florida earlier this year and last year. In fact, the congressional delegation—I made reference to this earlier in the hearing—made a great point to call the representatives of Blue Cross and Blue Shield in to discuss it. And the problem was caused by, I think, a turnover of computers, getting into another system At least that was the explanation that we were given. Do you think that the fraud may have been more rapid during that period of time because you did have such a huge backlog, and that there were problems in getting the new computer to work?

Mr. **Wachtel**. I don't think that that would have had any bearing on whether the folks who are going to perpetrate fraud are going to increase or step up their activities. Eventually, the claims are going to get processed.

Mr. **Shaw**. Well, they might get processed but the question is whether they are going to get screening. That is what I am talking about.

Mr. **Wachtel**. The screens that are in place on the front end are always there. The screens that are on the postpayment side are still in place, and eventually, they all go into the same funnel.

Mr. **Shaw**. Let me ask you another question with regard to the handling of complaints: I have heard from many people, and you heard today that telephone complaints are not received, that the people are told to go back and make a written complaint. Why is that?

Mr. **Wachtel**. It's much more acceptable to a court if a case goes before a court to have some written documentation of a complaint.

Mr. **Shaw**. I understand but the written complaint is not going to go into court. The testimony of the witness would be the best evidence. It certainly is not going to be their letter or their complaint. So that answer is really not responsive. But let me ask you another question as a followup to that: Why are these complaints not ever replied to? As I understand, when a letter is submitted to Blue Cross and Blue Shield—I have heard this from a number of people—they never hear back from you. It is kind of like a deep, dark hole.

Mr. **Wachtel**. That's a very interesting issue, one that I frankly don't understand simply because our office does respond to the beneficiary. For every beneficiary complaint that we receive that is resolved, a letter goes to the beneficiary.

Mr. **Shaw**. Wait a minute. You said the magic word, that is "resolved," and I have heard that. That can be 1½ or 2 years later, finally somebody gets a letter back saying that something was resolved. But I also understand that just the receipt of these complaints is not acknowledged by Blue Cross and Blue Shield. If you can prove me wrong on that, I would sure like to know the example of where you have timely responded to a complaint rather than waiting until it is resolved.

Mr. **Wachtel**. You are correct. We do not on the front end, at the present time, respond to those. We have looked into the possibility of issuing a postcard type response indicating to the folks who have written to us that we have received their complaint.

Mr. **Shaw**. It would certainly do a lot to—actually, it would make people feel they should complain because who is going to complain again if no one is listening.

Mr. **Wachtel**. We recognize that and intend to remedy that situation.

Mr. **Shaw**. I would like to go back one minute to the electronic transfer of billings and everything else. Are you required to acknowledge electronic billings?

Mr. **Wachtel**. I'm not sure I understand what you mean.

Mr. **Shaw**. Well, you get an electronic bill and you pay it. Right? All of the information is there. You testified as to this.

Mr. **Wachtel**. Yes, sir.

Mr. **Shaw**. My question is: Are you required to do so? The point that I am trying to make is: It seems like an unscrupulous provider getting a Medicare number is just about the same as getting someone's VISA number, and they can run it up, and they can run it real quickly and then close down and disappear. I mean, to me, this is the perfect scam, the perfect fraud, and it is really quite incredible. You have a situation where someone can come in and get a health provider number. They can go get a bunch of Medicare numbers. They can submit them just like you would on a VISA bill. They can get paid, and leave town, and close down, and be long gone and much richer for their crookedness. That is pretty much correct. Is it not?

Mr. **Wachtel**. Yes, sir, it is. The point where we find that we are flagging providers who do submit their claims electronically, and we find the need to ask them for medical information before we process their claim, we tell them that if they would submit their claims on paper instead of electronically, they might get faster service.

Mr. **Shaw**. This goes back, too, to the question of utilization review and why this should be done much more than every 6 months. Because when you find someone has got a new provider number, you do not have any experience with them, they have opened up shop, and all of sudden hundreds of thousands of dollars worth of claims come rolling in. I think at that point you should have a flag that would go up in the first few days or really the time that first batch came in, that somebody better go take a look at these people, that the system really is not working too well, and that you at Blue Cross and Blue Shield have an obligation to check these people out in some way or form, or at least slow down the payment so you can try to get some orderly review of what in the world they are doing. Because from the evidence we have gotten today, I think that is exactly what is happening.

Mr. **Wachtel**. It would be very difficult for us to do that on a daily basis, but your point is well made.

Mr. **Shaw**. Well, that gives me some satisfaction; I am not sure much, though. But I think that you all better go back and really take a close look at your utilization review, find out how it can be done more effectively. I would like also, Mr. Chairman, if they would submit a plan of utilization review at much closer intervals to this committee so we can take a look at it together with costing it out as to what it would cost to implement. I think this is a big problem. As a matter of fact, I think this is an area of fraud that is just now beginning to blossom, and I think it is going to just spread like wildfire across this entire country when people find out how easy it is to pick Uncle Sam's pocket. There are a lot of crooks out there that are really willing to go ahead and take a chance.

Mr. **Wachtel**. Yes, sir. We are one of the few carriers, I might add, that has in place at this time, and it is fairly new, a special unit to investigate nonphysician provider fraud and abuse. It was established in January primarily to look at DME suppliers as opposed to physician review.

Chairman PICKLE. Mr. Wachtel, I think what we have heard today here in this hearing in Fort Lauderdale may be just the tip of the iceberg. This scheme for milking Medicare by these mobile labs can just show what an enterprising person or persons can do if they want to tap the Medicare gold mine. If it is happening here, it follows that it is happening across the land. It seems for us, at a quick survey, that we need to see that these laboratories are regulated, that there is a certification to them, that there are standards that they have to meet. None of that is required now.

Furthermore, we do not require much information of a provider. It gets a provider number, and that person or that lab is in business. There is no prescreening. There is no regulation thereafter, except occasionally a 6-month review in some manner. We allow the physicians to sign documents after the billing or the tests have been made. We, in Congress, maybe just ought to start holding the doctors liable for signing bogus prescriptions rather than just hoping we get some reimbursement from the equipment supplier.

These are all clearly outrageous violations of the Medicare program, and if it is as widespread as we suspect, then we are allowing literally billions of dollars to be raked off the Medicare system to highbinders who obviously are in it just to get money.

I would hope that we could get more personnel for Blue Cross and Blue Shield, for the inspector general. It is not enough to say well, we have got difficulties on the Federal level. We are giving services now to 38 million people right here in this area every, every, every year. We are paying out billions of dollars, and yet we are allowing this money to be raked off. The Medicare program is a good program, and today is the 25th anniversary of the creation of Medicare. Yet, we are seeing fraud and abuses coming into this program that shock us and ought to embarrass us to our very foundation.

This committee is going to be holding hearings in other parts of the country on this same subject, and I hope we can do it as quickly as possible. My questions to you today have not been, nor Mr. Shaw's, critical of you and your operation per se, but as part of the system. I think, based on your testimony and the recommendations that you made that steps that should be taken, would mean that the Congress must also join in this request.

So I think you will see us being more active in this field, and I hope the word goes out from here that we are not going to just accept this to go on as business as usual, because that will wreck a system. These kinds of scams frighten us to know that that is going on. I presume it is going on because there is so much money, billions of dollars. It is going to get bigger because just in the space of 10 years the health program will be larger than all the other Federal agencies, many of them combined. So we are dealing with something that is extremely important, so we need your help and your cooperation. We need to give more leadership and attention to it, and I am sure that this committee will do that.

I want to thank Mr. Shaw for inviting us here to hold this hearing, and I compliment you for taking the initiative to listen to your constituents and help us get to the bottom of a lot of this. This has been very helpful, and I thank you for it. I thank all of the people who have come here to testify. If there is no other——

Mr. SHAW. Mr. Chairman, I would like to say just a few remarks in closing because I think there are some things that really jumped out of this hearing that are very badly needed. To begin with, we need to get State regulation and require regulation of these labs and State certification with some type of State regular review just as we require for physicians if these labs are going to be in any way reimbursed by the Medicare system. I think that is an absolute must. I think also we should require more frequent utilization review. I think that is going to expose a lot of these scam operations for what they are.

I think we need to also get a lot more out as far as public knowledge of this situation to let people know exactly that there is no free care under Medicare, because to offer it free without the payment of the 20 percent by the recipient in itself is illegal. I think, too, that the message has got to go out, and I think it has got to go out across this country, just because somebody has a medical degree does not mean that that is a ticket out of prison, that these are felonies that are being committed on a lot of these kickback schemes and a lot of these get rich schemes.

The doctors of this country are not immune from the law, either, and they can certainly go to jail for abuse of the system. I think we have to be very careful in the way we apply the law so that we do not destroy the relationship that exists between a doctor and his patient, but we also must be sure that the doctors do not become part of a scam operation by lending his name and certification or being enriched illegally under the law.

Again, Jake, I want to thank you for coming into the city of Fort Lauderdale. I hope you return, maybe next time in January or February; I hope you can stay longer. Again, I want to thank the mayor, the city manager and the City Commission of Fort Lauderdale for making this fine facility available to us. Most of all, I want to thank the wonderful people here in Fort Lauderdale, my constituents who came forward and made this situation known to us and gave me the opportunity to make the possibility of fraud known to the U.S. Congress, and I can assure them that we are listening and we are working to correct much of the system which is very much out of balance at this time. Thank you, sir.

Chairman PICKLE. I thank you, Mr. Shaw. This has been an interesting and a helpful hearing. We appreciate the cooperation of all those who testified, and again, Mr. Shaw, we thank you for making this hearing possible.

If there are no other questions, then the committee will stand adjourned.

[Whereupon, at 11:35 a.m., the hearing was adjourned.]

[Additional information requested of Blue Cross and Blue Shield during the hearing follow:]

Blue Cross
Blue Shield
of Florida

532 Riverside Avenue
P.O. Box 1798
Jacksonville, Florida 32231-0014
(904) 791-6268

Governmental & Legislative Relations

October 3, 1990

Mr. Christopher Smith
Assistant for Investigations
Committee on Ways and Means
1106 Longworth Building
Washington D.C. 20515

Dear Chris:

Enclosed is the additional information requested by members of the House Oversight Subcommittee during the hearing in Ft. Lauderdale. In reviewing the hearing transcript, I believe we have responded to all of the committee's requests for additional information.

We appreciated the opportunity to discuss our fraud and abuse identification efforts and share our suggestions with the Subcommittee on how we believe the program can be improved, not only in Florida, but on a national level.

If we can ever be of further assistance or if you have any questions regarding our response, please give me a call, (904) 791-6072.

Sincerely,

Jeff Wollitz

INFORMATION REQUESTED BY HOUSE OVERSIGHT SUBCOMMITTEE

1. Copy of written agreement or explanation summarizing BCBSF arrangement with Omnisonics, which allowed that company to resume participation in the Medicare program under a different name and provider number.

Response: Omnisonics was originally identified as having questionable billing practices through our routine prepayment review methods during October, 1989. At that time, Omnisonics was placed on flag (provider number 97813). In late November, Omnisonics' independent physiological laboratory provider number was also placed on flag.

Through ongoing conversations and two educational sessions we conducted with Omnisonics, we learned Omnisonics had changed its name to RX Sonics and received a new provider number.

This new provider number was immediately placed on flag and these providers remain on flag today, subject to 100 percent prepayment medical review. At no time was there an agreement, either written or verbal, to allow Omnisonics to change its name and provider number in order to resume participation in the Medicare program.

Omnisonics stated its intent was to make a fresh start with revised billing practices. At no time did Omnisonics make any attempts to hide the fact it had changed its name and company representatives were prompt in notifying us regarding the change in name and provider number.

2. Are the six DME businessess referred to Blue Cross and Blue Shield of Florida for investigation by Congressman Clay Shaw's office currently/continuing to participate in the Medicare program, either under the same names and provider numbers or new names and new provider numbers?

Response: The six DME suppliers referred to us for investigation by Congressman Shaw continue to have active provider numbers. However, during the past four months, they have all but stoppped submitting claims. Only one provider submitted more than 10 claims during the four month period. All claims submitted by these six suppliers continue to receive special prepayment scrutiny before any disposition is reached.

With the exception of Omnisonics, we are not aware of any of the other independent physiological labs chaning its name. In the case of Omnisonics, the same physician listed on the original provider number application is listed on the application for RX Sonics.

3. Summarize Blue Cross and Blue Shield of Florida's position on allowing OIG to have direct access to claims information in order to accelerate OIG's ability to investigate and prosecute potential fraud and abuse cases.

Response: We believe it would be a costly and unnecessary duplication of services to establish direct access to claims information capability for the OIG. Medicare Part B currently provides the OIG with a computer tape of claims information on a monthly basis which in almost all cases allows the OIG to promptly and effectively conduct its investigations.

We receive a large number of requests for information from the OIG's Office of Investigation and we make every effort to satisfy those requests on a timely basis. In many cases, however, the requests are extensive and involve data stored in the Federal archives in Kansas City, or data which must be extracted by a special computer run. In those instances, a longer amount of time is required to respond. However, we do understand the critical nature of these requests and give them priority handling.

Our Program Integrity efforts receive the highest priority possible within the funding limitations of the Medicare program. Each year, we receive between 5,000 and 6,000 complaints regarding alledged fraud and abuse. Each one of those complaints is assigned to an analyst and is worked to completion with notification of our findings to the complainant. In 1989, our Medicare B Utilization Review Department identified more than $7.5 million in overpayments as the result of fraud and abuse and recovered more than $5.75 million.

4. Why does Blue Cross and Blue Shield of Florida only conduct utilization review audits every six months? Submit a report on the feasibility, including financial and staffing needs, of conducting utilization review audits more frequently.

Response: Each year, we profile physician services billed to the Medicare program and compare the frequency of services billed by each physician with his peer group. Such profiling and screening is done every six months in accordance with Health Care Financing Administration (HCFA) requirements.

HCFA requires the carrier look at a certain percentage of its provider population and where appropriate take necessary corrective action to recover any overpayments that have been made. The carrier may also refer the physician to peer review; make an educational contact or send a warning letter.

Reviews of provider practices are time consuming, labor intensiveand involve retrieval of numerous claims as well as the acquisition of medical records from providers. HCFA believes a six-month period is a proper frequency to review utilization patterns of providers. Shorter timeframes would not show significant variances in practice patterns and would not be a feasible approach for postpayment utilization review and evaluation due to the large volume of cases reviewed on a postpayment basis.

In cases where unusual billing patterns are brought to our attention, such as the cases Congressman Shaw referred to us, there is a mechanism in place for flagging claims of providers immediately to scrutinize bills received prior to payment. In addition to this program, the carrier has in place HCFA mandated and carrier initiated screens for various services and frequencies. When providers exceed the screening thresholds, claims for these services are not allowed to follow the normal processing flow. The claims are shifted to an area which requests additional documentation supporting the services billed.

Once the information is received, the claims and medical records are reviewed by specially trained claims examiners and health care professionals. If the claims are medically necessary, they are released for payment. If they are not, denials are made on a prepayment basis and the claim is released. This is an ongoing operation which is responsible for the majority of claims reviewed by the carrier.

5. Submit a list of potential "special projects" which Blue Cross and Blue Shield of Florida could implement if additional funding were available to identify areas of fraud and abuse and to recoup funds.

Response: Among the projects are:

Physical therapy abuse by podiatrists -- There is strong suspicion some podiatrists are billing the Medicare program for unnecessary physical therapy. To be covered, the physical therapy must be related directly and specifically to an active written treatment regimen established by the physician and must be reasonable and necessary to the treatment of an individual's illness or injury. Services related to activities for the general good and welfare of patients do not constitute physical therapy services for Medicare payment.

More field staff to review physician records without prior notice to physicians -- We have received anonymous allegations that providers are editing medical records which have been requested for review by the carrier. With field staff, on-site record checks can be made. In addition to gathering accurate information, this activity should provide a deterrant for potential abuse of the program.

Routine foot care by podiatrists at nursing homes -- Some podiatrists have made arrangements with nursing homes to visit periodically to trim toenails of residents. Bills are submitted for covered services which are probably routine foot care, a non-covered service.

Cardiac catheterizations in non-PRO approved facilities -- Only cardiac catheterization services provided in free-standing cardiac catheterization facilities approved by the Peer Review Organization (PRO) are eligible for reimbursement. We believe some services may be billed which have not been furnished in approved facilities.

Chiro/MD/DO Data Match -- Chiropractors have teamed up with medical doctors and osteopaths in order to circumvent the program's non-coverage of services rendered by chiropractors. By having the MD or DO bill for services, such as x-rays and physical therapy treatments, Medicare is reimbursing the services. Typically, the MD or DO takes a percentage of the payments and forwards the balance to the chiropractor.

Expand review of independent physiological labs -- Some IPLs are under our scrutiny. However, because of the large number of IPLs in the state, many escape close scrutiny of services to assure that services are medically necessary and reasonable. These same screening patterns have been seen in free-standing clinics as well.

Expand review of ambulance companies -- A number of ambulance companies have been found to be submitting claims for non-covered services as covered transportation. Routine trips to kidney centers for dialysis have been identified as well as other trips which do not qualify as emergency transportation.

With additional funding, the scope of current reviews could be broadened and new projects undertaken.

6. Why does Blue Cross and Blue Shield of Florida require complaints from beneficiaries to be submitted in writing? Why doesn't BCBSF acknowledge the receipt of complaints and provide the beneficiary with a summation of case resolution?

Response: We do not require complaints from beneficiaries to be submitted in writing. Many of the complaints we receive are submitted through our Medicare toll-free numbers and are transferred to the program integrity unit. There are times, when we may request a beneficiary to follow-up a telephone call with a written complaint in order to begin a "trail of evidence." Action is taken based on the report of telephone contact.

Since we testified at the Subcommittee hearing, we have instituted an acknowledgement postcard following the receipt of a written or telephone complaint.

Once a case reaches a final resolution, the beneficiary is notified of the action taken.

Additional Statement

We would like to add an additional comment to the Subcommittee record.

During the past few years, Congress and HCFA have placed emphasis on making "prompt payment" to beneficiaries and providers. The establishment of prompt payment standards have placed additional burdens on carriers nationwide to turn claims around quickly.

At the same time, there has been a greater awareness of the need to review more claims prior to payment. Some of the reviews can be automated through a series of audits and edits while others require hands-on evaluation. The latter includes some of the mandated screens initiated by the carriers, screens mandated by HCFA, and all claims for providers who have been flagged for closer scrutiny.

Claims that receive closer scrutiny do experience some delays due to the necessity for obtaining additional documentation from the provider. This works counter to the "prompt payment" requirements. Of course, with additional funding, more resources can be devoted to prepayment review, but this will not resolve the claims delay issue associated with it.

FRAUD IN THE MEDICARE PROGRAM

TUESDAY, SEPTEMBER 25, 1990

House of Representatives,
Committee on Ways and Means,
Subcommittee on Oversight,
Washington, D.C.

The subcommittee met, pursuant to call, at 1:50 p.m., in room 1100, Longworth House Office Building, Hon. J.J. Pickle (chairman of the subcommittee) presiding.

Chairman Pickle. The committee will please come to order.

May I say at the beginning, we apologize for starting late. We have had a series of votes on the floor and many could not come here at the appointed time. So I appreciate your indulgence for waiting.

I also notice that both the inspector general and the HCFA people are already seated at the table together. I think that is all right. I was going to suggest that we do it that way anyway. So we can ask questions of the group instead of individually, and I think it will save time, since you have already predecided that and have seated yourself. We will continue.

I thank you. We appreciate your participation with the committee. We tried to get dates and had problems finding some open. We we thought we ought to go ahead. Thank you very much.

This hearing is part of the Subcommittee on Oversight's ongoing efforts to examine waste, fraud, and abuse in Federal programs under the Ways and Means jurisdiction. We will focus today on fraud in the Medicare program.

In July, the subcommittee held a hearing in Fort Lauderdale, Fla., on the issue of Medicare fraud. Today's hearing is being held to follow up on what we learned in Fort Lauderdale. At that hearing we heard about a group called the Healthy Heart. Healthy Heart would contact groups of senior citizens and offer to provide free cholesterol screenings. When the day came for the screenings, people with white coats and stethoscopes would show up with a lot of sophisticated looking equipment. After they had given simple cholesterol tests, they would advise the senior citizens that they needed followup tests. They told them that the followup tests, measuring blood flow, would be free, as Medicare would pay for them. Curiously enough, it seems that if you weren't covered by Medicare, you didn't need followup tests.

One of the patients who took the followup tests was told that she had nothing to worry about. Sadly, several months later, she had a heart attack. Most patients, however, did not get any test results. What they did get were copies of statements from Medicare indicating that Medicare had paid thousands of dollars per patient for these bogus tests. In Fort Lauderdale, Blue Cross and Blue Shield may have paid out over $3 million to the mobile labs involved in this fraud scheme.

At this hearing, I want to examine how the agency has responded to this obvious case of fraud, and to learn what can be done to stop the outflow of Medicare funds immediately when a scheme like this has been uncovered. We will hear today from the Office of Inspector General regarding what has been done about this Medicare fraud scheme and how widespread schemes like this are nationwide. We will also hear from the Health Care Financing Administration about what more can be done by Medicare carriers to catch fraud schemes like this before millions of dollars have been diverted from the Medicare program, and how Medicare participants can serve as a first line of defense against Medicare fraud.

We also want to try to get a picture of the scope of Medicare fraud nationwide. Costing upwards of $100 billion a year, the Medicare program is an inviting target for people who would like to get their fingers on some quick money. With our budget crisis, we have got to make sure that each Federal dollar spent is well spent. We can't afford to have money intended to serve the health needs of the elderly siphoned out of the Medicare program.

Now the Chair will recognize Mr. Schulze for any opening statement he might want to make.

Mr. SCHULZE. Mr. Chairman, I want to commend you for holding this second hearing on the very important issue of Medicare fraud and abuse. In Florida, the subcommittee learned of several different fraudulent Medicare schemes. A similar scheme took place in Philadelphia, just outside my congressional district.

Nationwide Medicare schemes cost taxpayers several billion dollars every year. These abuses also undermine the very nature and purpose of Medicare and threaten the trust that seniors and others have in the Medicare program.

There are a number of different solutions to prevent any further abuse. However, it is important to realize that fraud appears in many different forms. We learned of fraud schemes which involved unauthorized or excessive medical testing. Other schemes involve the sale of durable medical equipment which could have been sold at much cheaper prices. The subcommittee further learned of instances where billing companies fraudulently structured Medicare billings for providers in order to maximize Medicare payments.

Due to the widespread variety of types of fraud and abuse, any solutions we consider must take into account all the loopholes which exist, as well as the ingenuity of schemers who protect citizens against future abuse. Fortunately there are several intermediate steps we can take.

First and foremost, individuals need to know where and how to contact Medicare administrators if they suspect abuse. I challenge anyone to find the appropriate person to report potential fraud by looking in the phone book. It is high time the regulators realize the individual Medicare beneficiary is our front line of defense in the war on Medicare fraud.

Mr. Chairman, let me add parenthetically that I had my staff today call the local police department and say they wanted to report Medicare fraud. They said, well, what is Medicare? They said, where did the complaint come from? So they finally told the staff to call the police department in Baltimore. So they called the police department in Baltimore and the police department in Baltimore referred them to a police department in Pennsylvania. After four or five phone calls the staff finally gave up.

There is nowhere that people know how and where to report Medicare fraud. If anyone is able to negotiate through the bureaucratic maze and report a fraud case, the Medicare carriers, HCFA, or even OIG, still may not pursue it. More often than not the conscientious Medicare beneficiary never receives any word from the Medicare black hole.

Mr. Chairman, the Oversight Subcommittee letter to Chairman Stark outlines several basic reforms for the Medicare administrators. This letter is a good base from which the subcommittee can make its recommendations. In short, community involvement, public awareness, and appropriate legislative and administrative action are necessary for prevention against further Medicare abuse.

I look forward to today's hearing and our witnesses to learn of the progress made since the Florida hearing, as well as some further suggestions on ways to fight Medicare fraud.

Chairman PICKLE. Thank you, Mr. Schulze.

Mr. Anthony.

Mr. ANTHONY. Thank you, Mr. Chairman.

I have an opening statement. With your permission I will just insert it in the record at this point.

Chairman PICKLE. Without objection.

[The statement of Mr. Anthony follows:]

OPENING STATEMENT OF HON. BERYL ANTHONY, JR.

DO WE NEED A HIGH TECH APPROACH?

In 1985 a podiatrist began a mobile service in and around a retirement community in my district, Hot Springs, Ark. His scheme was simple—he went to a nursing home administrator and talked them out of the complete list of residents and their corresponding Medicare numbers; he then billed for a payable foot exam under Medicare which included cutting the patients toenails.

The problem is that every resident was billed as being examined when in fact they were not—some were already dead, some had amputations, some were in the hospital at the time, and most simply were not examined. There is no way under the current system to discover such a scheme unless tipped off—which was the case here—much less verify whether the service was performed—other than sending investigators out to check with each individual recipient as to whether they received the foot care.

Why are our utilization review computers not programed to "kick" when the program is billed for foot care when the beneficiary has a leg amputated? Do we have to expend a tremendous amount of man hours and resources to find out a person without a foot cannot have his toenails clipped?

Do we need regulations and education for a nursing home administrator who willingly disperses complete lists of Medicare numbers to any provider who pulls up to the door?

Should enforcement now turn toward a "high tech" approach where our Medicare carriers are programed to pick up something as simple as Medicare being billed for a wheel chair 6 months after the beneficiary is dead?

DO WE SHARE INFORMATION PROPERLY?

Currently under Medicare there is only a check on the credentials and provider history from State to State for physicians. So, if a physician in Arkansas is billing a few extra office visits just to pad his Medicare payments, gets caught and sanctioned by the program, then moves to Texas—the system notifies Texas before it can issue this crooked doctor a provider number.

The failure here is that a provider of durable medical equipment, a pharmacist, a home health person, or any number of other providers can illegally milk the system in my State and then go to Texas when the heat is on, get a new provider number and virtually start all over.

Should we look at a routine universal system to put in place a State by State information sharing system?

Should we consider a verification procedure of the providers professional credentials?

IS OUR SYSTEM HELPING TO DEFEAT OUR EFFORTS AGAINST FRAUD?

The opinion of one of my staff members who was a Medicare fraud investigator for 6 years is that we probably have the proper number of investigators in the field—but we need an oversight effort to provide the mechanisms to ferret out what are almost always highly sophisticated schemes.

In the case of a durable medical equipment dealer who was prosecuted and jailed by my staff person—their scheme was to bill Medicare for bed rails, a pull up bar, a three-prong cane, a commode chair, a wheelchair, and oxygen when all the beneficiary was getting from the DME supplier was simply a bed. He only got on to the scheme because of a competitors complaint about how much money they were making.

How can this happen when a physician is supposed to prescribe and certify patient need for a particular DME item?

Do we need to consider having the patients personal physician be the one doing the certification request?

Is allowing the DME's consulting physician to prescribe "medical necessity" kind of like leaving the fox in the hen house?

MAKING THE CRIMINAL CASE STICK

As a former prosecutor I know building a white collar criminal fraud case is tough—developing a trail of documents and making a jury understand a complex scheme is essential. We cannot be in a position to be thwarted in our prosecution efforts by a regulatory system that will not acknowledge that we may be losing millions of Medicare dollars a year to fraud.

It is my understanding from people who do Medicare fraud investigation that a common occurrence after completing a fruitful investigation that they discover "the enemy is us."

Is HCFA updating its' utilization programs to detect fraudulent patterns?

Are computer "kicks" being programed to tell the system that something just isn't right when a double amputee is being charged with a walking cane?

THE NEED TO UNDERSTAND WHILE COLLAR CRIME

In my State the Medicare/Medicaid fraud unit has a memorandum of understanding (MOU) with the carrier, the U.S. Attorney's Office, and the Federal Bureau of Investigation to share not only relevant information on criminal cases but to expedite document exchange—again, an experienced investigator will tell you this will make the difference in the criminal prosecution of a white collar criminal case. Should we consider a national standard of having MOU's on expedited document sharing for criminal Medicare fraud cases?

Mr. ANTHONY. I would mention to my good friend from Pennsylvania, I don't know what Pennsylvania's practice is, but in my own State we have a Medicare/Medicaid fraud unit that has a memorandum of understanding with the carrier, the U.S. attorney's office, and with the Federal Bureau of Investigation to share not only relevant information on criminal cases but to expedite documents in exchange. Having tried cases, I can tell you it is the speed with which you exchange the documents which really helps the experienced investigator nail down a potential positive prosecution of a white-collar crime.

I would just say to the witnesses, should we consider a national standard of having MOUs on expedited documents for fraud cases? Perhaps in your testimony you can make some reference to that.

I yield back the balance of my time.

Chairman PICKLE. Mr. McGrath.

Mr. McGRATH. Thank you, Mr. Chairman.

Mr. Chairman, we all appreciate your continued support of our subcommittee's activities. Today the subcommittee will discuss its investigation of the Medicare fraud and abuse. The previous subcommittee hearing on this subject was held in Florida and it uncovered the fact that the system is not working right. Individuals are taking advantage of the system and ripping off our seniors. Improvements in administering the Medicare program must be made in order to prevent schemes similar to the free mobile cholesterol screening program.

Medicare is the fourth largest category of Federal expenditures, after defense, Social Security, and interest on the national debt. During fiscal year 1990, Medicare is estimated to provide health coverage for over 33 million aged and disabled persons at a cost of over $109 billion. At a time when our Nation is grappling with its huge deficit and Medicare seems to be facing some unsustainable cuts, we cannot emphasize enough the importance of cracking down on Medicare scams which are costing the Government millions and millions of dollars.

I represent a district which has a senior population of 285,000. If the seniors are being swindled in Florida, I am confident that similar schemes are operating in my district and throughout New York and the Nation.

I look forward to our discussion of legislative remedies to curtail or eliminate Medicare fraud today. I welcome our panel of experts and look forward to their testimony.

Chairman PICKLE. This hearing being held today is an outgrowth, as I said in my statement, of a hearing we held in Fort Lauderdale. That abuse was brought to light because residents in that particular area, unable to get attention from proper authorities, contacted Congressman Clay Shaw's office. It was his district intervention and involvement in looking into this kind of fraud that enabled us to get the facts to find out what was happening.

I appreciate the leadership that Mr. Shaw has given to this committee and to the Congress. I would be pleased for him to make any statement.

Mr. SHAW. Thank you, Mr. Chairman. You are very kind with your remarks.

I would like to thank you for having given up your time and coming down to Fort Lauderdale, I might say in the summer, it was not in February, and to conduct these hearings which I think brought about the exposure of a very, very grave and growing problem in the Medicare system.

Mr. Chairman, I would ask that my full statement be placed in the record at this particular point.

Chairman PICKLE. Without objection.

[The statement of Mr. Shaw follows:]

OPENING STATEMENT OF HON. E. CLAY SHAW, JR.

Mr. Chairman, I'd like to again thank you for holding this followup hearing to the one held in Fort Lauderdale this past July 30. As the results of that hearing made painfully obvious, the issue of Medicare fraud is a serious one in the State of Florida. Because of the high concentration of seniors in my home State, Florida is a magnet for unscrupulous persons trying to make a career out of defrauding the Medicare system. As I mentioned then, over 18 percent of the total population of Florida receives Medicare benefits.

Today, however, we're interested in determining the extent to which Medicare scams are a national problem. It is only natural to suspect that wherever there are seniors covered by Medicare, there will be unscrupulous individuals willing and able to defraud the Government and, ultimately, the taxpayers by performing unnecessary and expensive medical tests. I am eager to hear from the HHS inspector general and the Health Care Financing Administration about not only the extent of this problem, but also what practical steps we can take to put a stop to it.

For those unfamiliar with the way the scams in South Florida worked, the modus operandi went like this. A representative from a mobile medical lab would contact seniors' organizations offering to provide "free" cholesterol screenings. These tests were then performed by official-looking technicians, who recommended immediate followup tests, but only if the senior had a Medicare number to give. Seniors were told these additional tests would be free to them, because Medicare would pick up the whole tab. Within weeks, seniors started receiving explanations of medical benefits (EOMBS) from Blue Cross and Blue Shield. These statements, however, indicated that Medicare had been fraudulently billed thousands of dollars for the tests, and that the seniors were responsible for 20 percent of the bill. Shortly thereafter, some of my constituents contacted me about this situation, which then led to the Oversight Subcommittee's hearing in July.

It is unconscionable that some people are willing to prey on seniors, who depend on quality health care. While we track these crooks nationwide, seniors can help prevent this sort of fraud by following a few simple suggestions: be very protective of your Medicare number, and only take medical equipment or tests that are recommended by your regular doctor.

Mr. Chairman, I again thank you for scheduling this followup hearing, and I am looking forward to hearing from our witnesses.

Mr. SHAW. The situation we found in Florida is rampant across the country. We have situations where people are getting Medicare provider numbers who are just downright crooks. They sort of borrow a doctor, bring him into an area where there are a large number of seniors. They have some kind of testing. At that time they get the beneficiary's Medicare number, and the doctors believe only those who don't belong to HMOs need all these extensive tests.

From the information we say in Florida, seems to me that most of the tests conducted were not bona fide tests, but the bills were sure bona fide. The Federal Government is paying out tens of millions of dollars a year in phony Medicare payments.

I think it is particularly interesting, Mr. Chairman, that this hearing is coming at this particular time, because we are seeing in the summit some drastic cuts that might be made in the Medicare system. I sincerely hope that these cuts are not made in the area that would uncover this fraud or prevent the fraud, or I can promise the cuts will be far exceeded by the amount of money the Federal Government will lose in phony Medicare payments.

We found a lot of holes in the system. We found you don't need to be licensed by the State or the local government to get Medicare provider numbers. We found that the solicitation is going on all over the place. People are giving out their Medicare number without any thought except for the thought that they don't think they will have to pay for it.

It was quite properly pointed out by some people in Fort Lauderdale, my congressional district, who came forward and, even though this was not costing them anything, they knew it was not right. They brought the situation to me. I am very grateful for the quick and rapid way you and the subcommittee went to Florida and held these hearings, and of course continuing these hearings here in Washington.

Thank you, Mr. Chairman.

Chairman PICKLE. Thank you, Mr. Shaw.

Our first statement will be by Barbara Gagel, Director of the Bureau of Program Operations with HCFA. Then we will have a statement by Mr. Larry Morey, who is the Deputy Inspector General for Investigations, Office of Inspector General. At the conclusion of both your statements, then I think the committee will want to ask questions.

You may proceed.

STATEMENTS OF BARBARA J. GAGEL, DIRECTOR, BUREAU OF PROGRAM OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. GAGEL. Thank you, Mr. Chairman.

I am pleased to have the opportunity to discuss the Health Care Financing Administration's program to detect and prevent Medicare fraud and abuse. I will, in the interest of time, summarize my testimony.

In a program as large and complex as Medicare, we do rely on the coordinated and aggressive actions of many people to preserve Medicare's program integrity. The cooperative efforts of Medicare beneficiaries, contractors, peer review organizations, and the Office of the Inspector General are essential to the success of the program.

Until 1983, the responsibility for Medicare program integrity lay solely with HCFA and its predecessor in the Social Security Administration. In 1983, Medicare law mandated that oversight responsibility reside in the Department of Health and Human Services' Office of the Inspector General. The OIG was also given the primary investigative authority to pursue fraud and abuse cases.

Nonetheless, Medicare beneficiaries and contractors act as our front line defense against fraud and abuse. Carriers and fiscal intermediaries are required to have methodologies for detecting and investigating suspected fraud and abuse cases to their fullest potential and, when appropriate, refer them to the OIG.

Beneficiaries' allegations are the impetus for most fraud and abuse investigations. Medicare beneficiaries often uncover potential fraud and abuse evidence and are a crucial information source, particularly for part B fraud and abuse cases.

Carriers receive Medicare beneficiary complaints directly by mail, by telephone, and by personal visits. Other complaints are a result of referrals from providers, Social Security Administration field offices, HCFA regional offices and the OIG. In addition, fraud and abuse are discovered by carrier internal controls, reviews, and audits.

HCFA requires carriers to begin investigation within 30 days of receipt of a complaint or identification of a case of potential fraud or abuse. On average, investigations are completed in about 2 months.

Each carrier maintains a program integrity unit, managed by a program integrity coordinator. The coordinator reviews complaints and other leads and decides if further investigation, or as we call it, case development, is warranted.

Generally, when a complaint is lodged, the carrier reviews Medicare records of the provider in question to determine whether there are other complaints about that particular provider. In addition, the contractor may flag that provider's claims for special prepayment and/or postpayment review to identify evidence of fraud or abuse. If more information is needed, the complainant is contacted.

Special care is taken to divorce the complainant from the investigative process to protect the identity of beneficiaries. If the allegation is found to be based on a processing or clerical error or a misunderstanding, then the complainant is notified, corrective action is taken, and the case is closed. This occurs in the majority of cases.

If the review of the provider's file concludes that fraud or abuse may exist, an expanded investigation is undertaken. The carrier conducts an indepth review of its records on the provider in question and then, if warranted, contacts a sample of beneficiaries who received the same type of service from the provider as that described in the complaint. In instances where the medical necessity of a service is in question, carrier medical staff and peer review organizations are consulted. If there are substantial instances of possible fraud and abuse, the carrier refers the case to the OIG for full-scale investigation.

Carriers are specifically advised that a telephone call is the preferred method of beneficiary contact and that care should be taken not to upset beneficiaries. This is particularly important since fraud or abuse has not been determined, and we do not wish to undermine beneficiaries' confidence in their providers or harm the reputation of the provider.

Let me briefly discuss the Healthy Heart program. Under this program, six Medicare certified laboratories were billing Medicare for tests performed as a followup to free cholesterol screening. The carrier was informed of this scheme by Congressman Shaw in response to complaints that he received from his beneficiaries.

The carrier immediately notified the inspector general's office and began flagging claims from the laboratories involved in the Healthy Heart scheme for prepayment review. Most of the claims have since been returned to the laboratories for documentation that the tests were medically necessary and that they were ordered by a physician. This documentation has not been forthcoming and the claims have not been paid.

As a result of this effort on the part of the carrier, the number of claims processed from these six labs has dropped from 1,400 approximately in the first 4 months of 1990 to 99 claims from May through September of this year. The carrier is continuing its prepayment review on claims from these six labs.

The carrier has also broadened its review to include a sample of claims from the involved laboratories dating back to October 1988. If this review reveals that erroneous payments had been made, we will, of course, seek repayment to the Medicare trust fund.

The inspector general's office will inform you of their followup of this investigation.

Our goal is to control and prevent fraud and abuse through a variety of methods combining surveillance, enforcement, and deterrence. Since 1988, we have significantly strengthened our program integrity process in collaboration with the inspector general's office. We believe our efforts have had a favorable impact in detecting these fraud and abuse cases. Between October 1, 1989, and June 30, 1990, the carriers investigated over 29,000 cases and referred about 1,900 of those to the OIG.

Thank you for giving me the opportunity to appear before you today.

[The prepared statement follows:]

STATEMENT OF BARBARA J. GAGEL, DIRECTOR, BUREAU OF PROGRAM OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman and Members of the Committee.

I am pleased to have this opportunity to discuss the Health Care Financing Administration's program to detect and prevent Medicare fraud and abuse. In a program as large and complex as Medicare, we rely on the coordinated and aggressive actions of many to preserve Medicare's program integrity. The cooperative efforts of Medicare beneficiaries, contractors, peer review organizations, and the Office of the Inspector General are essential.

The Medicare program covers health care services for 34 million beneficiaries provided by over 12,000 hospitals, 10,000 skilled nursing homes, 5,000 home health agencies, 125,000 medical equipment suppliers, and 750,000 physicians, as well as thousands of other assorted providers and suppliers. Medicare contracts with 84 private organizations, usually private health insurance firms, to act as the government's fiscal agent in processing Medicare claims and payments to Medicare beneficiaries, physicians, hospitals, and other suppliers. Medicare contractors are called fiscal intermediaries for Part A and carriers for Part B. Contractors processed over 400 million claims in FY 1989.

BACKGROUND

Until 1983, the responsibility for Medicare program integrity lay solely with HCFA and its predecessor in the Social Security Administration. In 1983, Medicare law mandated that oversight responsibility reside in the Department of Health and Human Services' Office of the Inspector General. The OIG was also given the primary investigative authority to pursue fraud and abuse cases.

Nonetheless, Medicare beneficiaries and contractors act as our front line defense against fraud and abuse. Carriers and fiscal intermediaries are required to have training programs and methodologies for detecting and investigating suspected fraud and abuse cases to their fullest potential and, if appropriate, to refer them to the OIG.

Under Medicare, fraud is defined as the intentional deception or misrepresentation by a provider who knows the action could result in an unauthorized benefit to himself or to some other person. For example, billing for services or supplies that were not provided is considered to be fraud. Abuse, on the other hand, refers to incidents or practices of providers, which, although not usually considered fraudulent, are inconsistent with accepted medical, business, or fiscal practices. Examples include excessive charges and unwarranted utilization of services. Both fraud and abuse could result in harm to beneficiaries through substandard or unnecessary care and in increased program costs due to improper payments.

MEDICARE CARRIER PROGRAM INTEGRITY ACTIVITIES

Beneficiaries' allegations are the impetus for most fraud and abuse investigations. Medicare beneficiaries often uncover potential fraud and abuse evidence and are a crucial information source particularly for Part B fraud and abuse cases.

Carriers receive Medicare beneficiary complaints directly by mail, by telephone, and by personal visits. Other complaints are a result of referrals from providers, Social Security Administration field offices, HCFA regional offices and the OIG. In addition, fraud and abuse are discovered by carrier internal controls, reviews, and audits.

HCFA requires carriers to begin investigation within 30 days of receipt of a complaint or identification of a case of potential fraud or abuse. On average, investigations are completed in about 2 months.

Each carrier maintains a Program Integrity Unit, managed by a program integrity coordinator. The coordinator reviews complaints and other leads and decides if further investigation or as we call it, case development is warranted.

Complaint Process When a complaint is lodged, the carrier reviews Medicare records of the provider in question to determine whether there are other complaints about that particular provider. In addition, the contractor may flag that provider's claims for special prepayment and/or postpayment review to identify evidence of fraud or abuse. If more information is needed, the complainant is contacted. Special care is taken to divorce the complainant from the investigative process to protect the identity of beneficiaries. If the allegation is found to be based on a processing or clerical error or a misunderstanding, then the complainant is notified, corrective action is taken, and the case is closed. This occurs in the majority of cases.

If the review of the provider's file concludes that fraud or abuse may exist, an expanded investigation is undertaken. The carrier conducts an in-depth review of its records on the provider in question and then, if warranted, contacts a sample of beneficiaries who received the same type of service from the provider as that described in the complaint. In instances where the medical necessity of a service is in question, carrier medical staff and peer review organizations are consulted. Carriers are specifically advised that a telephone call is the preferred method of beneficiary contact and that care should be taken not to upset beneficiaries. This is particularly important since fraud or abuse has not been determined, and we do not wish to undermine beneficiaries' confidence in their providers or harm the reputation of the provider.

If there are substantial instances of possible fraud and abuse, the carrier refers the case to the OIG for full-scale investigation.

Healthy Heart Program Let me briefly discuss the case I know is of most interest to you: the Healtny Heart program. Under this program, six Medicare certified laboratories were billing Medicare for testing performed as a follow-up to free cholesterol screening. Our carrier, Blue Cross/Blue Shield of Florida, was notified by Congressman Shaw's office that he had been receiving complaints from Medicare beneficiaries about this program.

The carrier immediately notified the Inspector General's Office and began flagging claims from the laboratories involved in the Health Heart scheme for prepayment review. Most of the claims have since been returned to the laboratories for documentation that the tests were medically necessary and that they were ordered by a physician. This documentation has not been forthcoming and the claims have not been paid. The carrier is continuing its prepayment review on claims from these six laboratories.

The carrier has also broadened its review to include a sample of claims from the involved laboratories dating back to October 1988. If this review reveals that erroneous payments had been made, we will, of course, seek repayment.

We understand that the developer of the Healthy Heart Program is under investigation by the Inspector General.

Contractor Evaluation The HCFA regional offices closely monitor carrier performance of fraud and abuse functions. A detailed Contractor Performance Evaluation is conducted annually which examines all aspects of contractors' Medicare activities.

Specific performance evaluation standards focus on the adequacy of the carrier's detection and development of potential fraud and abuse cases.

Recent Strengthening of the Program Integrity Process In 1988, in response to recommendations made by the OIG, we strengthened our program integrity process. We collaborated with OIG to issue revised, highly detailed manual instructions to our contractors on how to investigate cases of potential fraud or abuse. We strengthened our Contractor Performance and Evaluation Program requirements to ensure that the new instructions were fully implemented. We doubled the sample size of cases reviewed and the carrier's performance of fraud and abuse activities is more heavily weighted in the total performance evaluation process. In addition, we revised and strengthened our postpayment review procedures. We began to collect and monitor data on OIG referrals and cost savings electronically. Lastly, we cooperated with the OIG in sponsoring a national fraud and abuse training conference for our contractors in 1989, and we are planning another such conference for later this year.

We believe that our efforts in this area have had a favorable impact on detecting potential fraud and abuse. This is evidenced by a dramatic increase in the number of cases developed and referred to the OIG. Between October 1, 1989 and June 30, 1990, the carriers investigated over 29,000 cases and referred about 1,900 of those to the OIG.

BENEFICIARY OUTREACH

The majority of Medicare beneficiaries inquiries into potentially fraudulent or abusive behavior are prompted by the Explanation of Medicare Benefits. Beneficiaries are sent an EOMB which details the date and type of service that was furnished, the provider who billed for the service and the amount billed. If the beneficiary believes there is an error, for example either the listed service was not received or the amount the physician charged seems too high, they can call a toll free number which is provided on the EOMB to discuss the matter. The carrier then reviews the beneficiary's computerized file to see if the issue can be resolved. If it appears there is a question, the carrier logs the complaint and initiates an investigation.

Because beneficiaries are such an essential resource in our defense against fraud and abuse, it is important that they understand the information they receive. Beneficiaries are often confused by Medicare's elaborate insurance and billing processes. We are diligently working to improve communication with beneficiaries to ensure that the information they receive is comprehensible.

For that reason, we have established a workgroup within HCFA to look at better ways to serve Medicare beneficiaries. We have met with provider and beneficiary groups to enlist their support for our beneficiary communication initiative.

The goals of the workgroup are to improve the consistency, clarity and effectiveness of beneficiary communications. For example, the Explanation of Medicare Benefits is presently under scrutiny. We want to eliminate bureaucratic jargon and technical phrases.

CONCLUSION

Our program integrity goal is to control and prevent fraud and abuse through a variety of methods that combine surveillance, enforcement, and deterrence.

I believe the recent changes to carrier activities and their continued education and training will significantly improve our efforts to prevent Medicare fraud and abuse. Further beneficiary outreach through our beneficiary communication initiative will also aid in our efforts.

I look forward to working with the Congress and the OIG in order to continue our progress in preventing Medicare fraud and abuse.

I would be happy to answer any questions you may have.

Chairman Pickle. Mr. Morey, you may proceed.

STATEMENT OF LARRY D. MOREY, DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY ROBERT SIMON, ASSISTANT INSPECTOR GENERAL, CRIMINAL INVESTIGATIONS

Mr. Morey. Thank you very much.

Today I have with me Robert Simon. He is the Assistant Inspector General for Investigations. For your information and of interest to the committee, prior to Mr. Simon's current assignment here in Washington, D.C., he was the Regional Inspector General for Investigations in Atlanta. He has worked in Florida and is familiar with the health care problems in the State of Florida. He might be helpful in answering questions later.

I will summarize my testimony and ask that you include my complete testimony for the record.

Chairman Pickle. Both of your statements will be included in their entirety.

Mr. Morey. The Office of Inspector General has a statutory responsibility to protect the integrity of departmental programs as well as the health and welfare of beneficiaries served by these programs. Through our comprehensive program of investigations, audits, program evaluations, and inspections, we frequently identify weaknesses that impact adversely on the Medicare program making it susceptible to fraud.

Investigations of health care fraud have produced significant recoveries for the Medicare program and for the OIG. In fiscal year 1990, our criminal investigations obtained over 155 convictions for all health care cases. We have also imposed 900 successful administrative actions against health care providers and suppliers who violated provisions of the Medicare and Medicaid programs.

Our work has also resulted in the imposition of over 75 civil monetary penalties. In fiscal year 1990, about $5.8 billion in settlements, restitutions, receivables and savings have resulted from OIG activities, and over $1.5 billion of those savings pertained to the Medicare and Medicaid programs.

Recently, we testified on Medicare fraud before this committee in Florida. As we pointed out, Florida's large elderly population is particularly vulnerable to fraudulent health care schemes and tactics. Over the last 4 years, as a result of cases we have investigated in Florida, we have recouped over $934,000 in criminal recoveries, $210,000 in criminal restitutions, and $426,000 in criminal fines. We also have levied civil monetary penalties of about $6,723,000. Currently, we have about 40 health care cases under active investigation in Florida.

Under Medicare, fraud is defined as the intentional deception or misrepresentation by a provider who knows the action could result in an unauthorized benefit to himself or some other person. There are certain patterns of fraud which have manifested themselves over the years. We testified about several such schemes at the Florida hearing.

These include: unauthorized or excessive tests; overzealous marketing by durable medical equipment suppliers; and contractor fraud.

These same frauds are prevalent throughout the United States, but vary in intensity, often depending upon the contractor and the elderly population of a State. Let me briefly describe some of the more prevalent fraud schemes.

As you know, we have been investigating possible Medicare fraud on the part of testing services. Along with your subcommittee, we have concerns about the testing procedures and the prices charged for the tests.

In our recent testimony, we discussed how Medicare beneficiaries are lured in under the pretext of a free cholesterol or other medical test. After the free checks, they are told that they have conditions requiring further testing—at no cost to them if they provide a Medicare or other insurance number. Many are referred to mobile labs for further testing, where they are pressured into taking costly, unnecessary tests, such as vascular and x ray examinations.

Eventually, Medicare and private insurance companies are billed hundreds of thousands of dollars in charges for these additional examinations. Often, this billing is for tests which were not actually performed.

We are investigating numerous instances in which unauthorized or excessive tests may have been performed. However, as you know, we have to limit testimony to those facts which are not under the protection of the U.S. district court, Department of Justice or Federal grand juries, which are reviewing evidence in many of these cases. We have previously briefed subcommittee staff on many of these cases, and would be pleased to discuss them with the subcommittee at your convenience.

In addition to conducting investigations such as these, the OIG is also conducting a study concerning quality assurance in independent physiological laboratories (ILPs) by examining three aspects of the industry—regulation, personnel qualifications and equipment standards.

A May 1989 OIG report entitled "Financial Arrangements Between Physicians and Health Care Businesses" details the effects of physician ownership and compensation arrangements with health care entities, including IPLs. This study indicated that IPLs operated with little or no regulation or standards imposed by either Government or the IPL industry itself. We will be releasing our report shortly.

Another area I would like to reemphasize is durable medical equipment. As investigators for fraud and abuse in health care, the OIG is seeing a nationwide increase in problems with DME suppliers. In the last 4 years, we received about 750 complaints of fraudulent activity by DME companies. Many of these allegations were substantiated. and over 360 cases were initiated.

During this same period, we scored about 485 convictions for all health care cases, about 30 of which were against DME suppliers. In the DME area, our work also resulted in 86 DME provider sanctions and civil monetary penalties totalling $11.8 million.

As with testing services, we have found that DME companies often use intense, high pressure marketing techniques to get beneficiaries to order equipment they don't really need. Through television solicitations, routine screenings, or mass mailings, beneficiaries are told that equipment can be supplied in their homes at no cost. The companies obtain the beneficiary's primary physician's name and health insurance claim numbers. The companies then prepare false authorization documents, known as certificates of medical necessity, needed to bill the equipment to Medicare. These documents often list DME which the beneficiary has not requested, and show false diagnoses. The physicians are then pressured to sign the fraudulent authorizations, sometimes after being threatened with patient loss.

Another area is contractor fraud. In an effort to curb rising hospital costs while ensuring that Medicare beneficiaries receive high-quality medical care, the Congress established the Peer Review Organization (PRO) program through the Tax Equity and Fiscal Responsibility Act of 1982.

Under the program, which began operating in 1984, PROs review hospital records for about one-fourth of all Medicare patient admissions. Medically trained personnel, usually doctors, registered nurses or accredited medical records technicians, screen cases for instances of unnecessary or poor quality care.

We rely heavily on the PROs to identify physicians whose care of Medicare beneficiaries may not meet quality and utilization standards. Given the continuing rise in the number and cost of Medicare claims, it is imperative that PROs accurately screen cases for instances of unnecessary or poor quality care. However, we have uncovered problems with Medicare contractors, including two PROs. This is particularly serious, because PROs carry out greatly needed functions to insure the accuracy of Medicare payments.

As nationwide investigators for fraud and abuse, we have attacked the problem of Medicare fraud from many different angles. Part of this is due to the fact that we never know where Medicare fraud will surface next.

In addition, we have attempted to balance the Department's efforts to control Medicare expenditures and the increasing level of fraud against the competing priorities among beneficiaries, contractors, and providers. Our recommendations over the years, both to Congress and the Department, have attempted to take into consideration the concerns of all parties.

This concludes my testimony. We are available to answer any questions.

[The prepared statement and attachment follow:]

STATEMENT BY
LARRY D. MOREY
DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS
OFFICE OF INSPECTOR GENERAL
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT
COMMITTEE ON WAYS AND MEANS
SEPTEMBER 25, 1990

GOOD MORNING, MR. CHAIRMAN, AND MEMBERS OF THE SUBCOMMITTEE. I AM LARRY MOREY, DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS WITH THE OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES. I AM ACCOMPANIED THIS MORNING BY ROBERT SIMON, ASSISTANT INSPECTOR GENERAL FOR INVESTIGATIONS. WE ARE PLEASED TO HAVE THE OPPORTUNITY TO FURTHER REPORT ON OUR OFFICE'S PROGRESS IN INVESTIGATING MEDICARE FRAUD. YOU HAVE ASKED US TO TESTIFY ON THE ISSUE OF MEDICARE FRAUD. OUR TESTIMONY WILL ATTEMPT TO ADDRESS THIS QUESTION BY SHOWING THE WAYS IN WHICH MEDICARE FRAUD OCCURS.

BACKGROUND

THE OFFICE OF INSPECTOR GENERAL (OIG) HAS A STATUTORY RESPONSIBILITY TO PROTECT THE INTEGRITY OF DEPARTMENTAL PROGRAMS AS WELL AS THE HEALTH AND WELFARE OF BENEFICIARIES SERVED BY THOSE PROGRAMS. THROUGH OUR COMPREHENSIVE PROGRAM OF INVESTIGATIONS, AUDITS, PROGRAM EVALUATIONS, AND INSPECTIONS, WE FREQUENTLY IDENTIFY WEAKNESSES THAT IMPACT ADVERSELY ON THE MEDICARE PROGRAM MAKING IT SUSCEPTIBLE TO FRAUD.

INVESTIGATIONS OF HEALTH CARE FRAUD HAVE PRODUCED SIGNIFICANT RECOVERIES FOR THE MEDICARE PROGRAM AND THE OIG. IN FISCAL YEAR (FY) 1990, OUR CRIMINAL INVESTIGATIONS ATTAINED OVER 155 CONVICTIONS FOR ALL HEALTH CARE CASES. WE HAVE ALSO IMPOSED 900 SUCCESSFUL ADMINISTRATIVE ACTIONS AGAINST HEALTH CARE PROVIDERS AND SUPPLIERS WHO VIOLATED PROVISIONS OF THE MEDICARE AND MEDICAID PROGRAMS. OUR WORK HAS ALSO RESULTED IN THE IMPOSITION OF OVER 75 CIVIL MONETARY PENALTIES. IN FY 1990, $5.8 BILLION IN SETTLEMENTS, RESTITUTIONS, RECEIVABLES AND SAVINGS HAVE RESULTED FROM OIG ACTIVITIES AND IMPLEMENTATION OF OIG RECOMMENDATIONS. OVER $1.5 BILLION OF THOSE SAVINGS PERTAINED TO THE MEDICARE AND MEDICAID PROGRAMS.

INVESTIGATIONS OF HEALTH CARE FRAUD IN FLORIDA

RECENTLY, WE TESTIFIED ON MEDICARE FRAUD BEFORE THIS COMMITTEE IN FLORIDA. AS WE POINTED OUT, FLORIDA'S LARGE ELDERLY POPULATION IS PARTICULARLY VULNERABLE TO FRAUDULENT HEALTH CARE SCHEMES AND TACTICS. OVER THE LAST FOUR YEARS, AS A RESULT OF CASES WE'VE INVESTIGATED IN FLORIDA, WE HAVE RECOUPED OVER $934,000 IN CRIMINAL RECOVERIES, $210,000 IN CRIMINAL RESTITUTIONS, AND $426,000 IN CRIMINAL FINES. WE ALSO HAVE LEVIED CIVIL MONETARY PENALTIES OF ABOUT $6,723,000. CURRENTLY, WE HAVE ABOUT 40 HEALTH CARE CASES UNDER ACTIVE INVESTIGATION IN FLORIDA.

UNDER MEDICARE, FRAUD IS DEFINED AS THE INTENTIONAL DECEPTION OR MISREPRESENTATION BY A PROVIDER WHO KNOWS THE ACTION COULD RESULT IN AN UNAUTHORIZED BENEFIT TO HIMSELF OR SOME OTHER PERSON. THERE ARE CERTAIN PATTERNS OF FRAUD WHICH HAVE MANIFESTED THEMSELVES OVER THE YEARS. WE TESTIFIED ABOUT SEVERAL SUCH SCHEMES AT THE FLORIDA HEARING. THESE INCLUDE:

- UNAUTHORIZED OR EXCESSIVE TESTS;
- OVERZEALOUS MARKETING BY DURABLE MEDICAL EQUIPMENT SUPPLIERS; AND
- CONTRACTOR FRAUD

THESE SAME FRAUDS ARE PREVALENT THROUGHOUT THE UNITED STATES, BUT VARY IN INTENSITY, OFTEN DEPENDING UPON THE CONTRACTOR AND THE ELDERLY POPULATION OF A STATE. LET ME BRIEFLY DESCRIBE SOME OF

THE MORE PREVALENT FRAUD SCHEMES.

1. UNAUTHORIZED OR EXCESSIVE TESTS

AS YOU KNOW, WE HAVE BEEN INVESTIGATING POSSIBLE MEDICARE FRAUD ON THE PART OF TESTING SERVICES. ALONG WITH YOUR SUBCOMMITTEE, WE HAVE CONCERNS ABOUT THE TESTING PROCEDURES AND THE PRICES CHARGED FOR THE TESTS.

IN OUR RECENT TESTIMONY, WE DISCUSSED HOW MEDICARE BENEFICIARIES ARE LURED IN UNDER THE PRETEXT OF A FREE CHOLESTEROL OR OTHER MEDICAL TEST. AFTER THE FREE CHECKS, THEY ARE TOLD THAT THEY HAVE CONDITIONS REQUIRING FURTHER TESTING -- AT NO COST TO THEM IF THEY PROVIDE A MEDICARE OR OTHER INSURANCE NUMBER. MANY ARE REFERRED TO MOBILE LABS FOR FURTHER TESTING, WHERE THEY ARE PRESSURED INTO TAKING COSTLY, UNNECESSARY TESTS, SUCH AS VASCULAR AND X-RAY EXAMINATIONS. EVENTUALLY, MEDICARE AND PRIVATE INSURANCE COMPANIES ARE BILLED HUNDREDS OF THOUSANDS OF DOLLARS IN CHARGES FOR THESE ADDITIONAL EXAMINATIONS. OFTEN, THIS BILLING IS FOR TESTS WHICH WERE NOT ACTUALLY PERFORMED.

WE ARE INVESTIGATING NUMEROUS INSTANCES IN WHICH UNAUTHORIZED OR EXCESSIVE TESTS MAY HAVE BEEN PERFORMED. HOWEVER, AS YOU KNOW, WE HAVE TO LIMIT TESTIMONY TO THOSE FACTS WHICH ARE NOT UNDER THE PROTECTION OF THE U.S. DISTRICT COURT, DEPARTMENT OF JUSTICE OR FEDERAL GRAND JURIES, WHICH ARE REVIEWING EVIDENCE IN MANY OF THESE CASES. WE HAVE PREVIOUSLY BRIEFED SUBCOMMITTEE STAFF ON MANY OF THESE CASES, AND WOULD BE PLEASED TO DISCUSS THEM WITH THE SUBCOMMITTEE AT YOUR CONVENIENCE.

IN ADDITION TO CONDUCTING INVESTIGATIONS SUCH AS THESE, THE OIG IS ALSO CONDUCTING A STUDY CONCERNING QUALITY ASSURANCE IN INDEPENDENT PHYSIOLOGICAL LABORATORIES (ILPs) BY EXAMINING THREE ASPECTS OF THE INDUSTRY - REGULATION, PERSONNEL QUALIFICATIONS AND EQUIPMENT STANDARDS.

A MAY 1989 OIG REPORT ENTITLED "FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES" DETAILS THE EFFECTS OF PHYSICIAN OWNERSHIP AND COMPENSATION ARRANGEMENTS WITH HEALTH CARE ENTITIES, INCLUDING IPLs. THIS STUDY INDICATED THAT IPLs OPERATED WITH LITTLE OR NO REGULATION OR STANDARDS IMPOSED BY EITHER GOVERNMENT OR THE IPL INDUSTRY ITSELF. WE WILL BE RELEASING OUR REPORT SHORTLY.

2. DURABLE MEDICAL EQUIPMENT SUPPLIERS

ANOTHER AREA I WOULD LIKE TO REEMPHASIZE IS DURABLE MEDICAL EQUIPMENT. AS INVESTIGATORS FOR FRAUD AND ABUSE IN HEALTH CARE, THE OIG IS SEEING A NATIONWIDE INCREASE IN PROBLEMS WITH DME SUPPLIERS. IN THE LAST FOUR YEARS, WE RECEIVED ABOUT 750 COMPLAINTS OF FRAUDULENT ACTIVITY BY DME COMPANIES. MANY OF THESE ALLEGATIONS WERE SUBSTANTIATED, AND OVER 360 CASES WERE INITIATED. DURING THIS SAME PERIOD, WE SCORED ABOUT 485 CONVICTIONS FOR ALL HEALTH CARE CASES, ABOUT 30 OF WHICH WERE AGAINST DME SUPPLIERS. IN THE DME AREA, OUR WORK ALSO RESULTED IN 86 DME PROVIDER SANCTIONS AND CIVIL MONETARY PENALTIES TOTALLING $11.8 MILLION.

AS WITH TESTING SERVICES, WE HAVE FOUND THAT DME COMPANIES OFTEN USE INTENSE, HIGH PRESSURE MARKETING TECHNIQUES TO GET BENEFICIARIES TO ORDER EQUIPMENT THEY DON'T REALLY NEED. THROUGH TELEVISION SOLICITATIONS, ROUTINE SCREENINGS, OR MASS MAILINGS, BENEFICIARIES ARE TOLD THAT EQUIPMENT CAN BE SUPPLIED IN THEIR HOMES AT NO COST. THE COMPANIES OBTAIN THE BENEFICIARY'S PRIMARY PHYSICIAN'S NAME AND HEALTH INSURANCE CLAIM NUMBERS. THE COMPANIES THEN PREPARE FALSE AUTHORIZATION DOCUMENTS, KNOWN AS CERTIFICATES OF MEDICAL NECESSITY, NEEDED TO BILL THE EQUIPMENT TO MEDICARE. THESE DOCUMENTS OFTEN LIST DME WHICH THE BENEFICIARY HAS NOT REQUESTED, AND SHOW FALSE DIAGNOSES. THE PHYSICIANS ARE THEN PRESSURED TO SIGN THE FRAUDULENT

AUTHORIZATIONS, SOMETIMES AFTER BEING THREATENED WITH PATIENT LOSS.

WE UNDERSTAND THAT IT IS NOT UNUSUAL FOR DME SUPPLIERS, HOSPITAL OUTPATIENT DEPARTMENTS AND SOME PHYSICIANS TO ROUTINELY WAIVE COINSURANCE AND DEDUCTIBLE AMOUNTS UNDER MEDICARE PART B. UNDER THIS PRACTICE, INDIVIDUALS AND ENTITIES PROVIDING OR SUPPLYING ITEMS OR SERVICES AS A ROUTINE MATTER DO NOT CHARGE MEDICARE BENEFICIARIES THE MEDICARE PART B DEDUCTIBLE OR THE OTHER 20 PERCENT COINSURANCE AMOUNTS. IF THE PHYSICIAN OR SUPPLIER IS PAID ON THE BASIS OF CHARGES, AND THE PHYSICIAN OR SUPPLIER DOES NOT ACCURATELY REPORT WHAT HE OR SHE ACTUALLY CHARGED THE BENEFICIARY, HE OR SHE MAY HAVE PRESENTED OR CAUSED TO BE PRESENTED A FALSE CLAIM. WE WILL SOON ISSUE A SPECIAL FRAUD ALERT TO THE PROVIDER COMMUNITY REGARDING ROUTINE WAIVERS OF COINSURANCE AND DEDUCTIBLE AMOUNTS.

IT SHOULD BE NOTED THAT MEDICARE PART B PAYMENTS, WHICH INCLUDES PAYMENTS FOR DME, HAVE INCREASED 13 PERCENT, ON AVERAGE, OVER THE LAST FOUR (4) YEARS. IN VIEW OF THESE ESCALATING COSTS, IT IS IMPERATIVE THAT WE DO EVERYTHING WE CAN TO ASSURE THAT, AMONG OTHER THINGS, MEDICARE DOES NOT PAY FOR UNNECESSARY DME PROVIDED BY COMPANIES THAT OBTAIN AUTHORIZATION AFTER THE EQUIPMENT HAS BEEN PROVIDED, SO THAT RESPONSIBLE DME COMPANIES ARE NOT FORCED TO RAISE THEIR PRICES.

3. CONTRACTOR FRAUD

IN AN EFFORT TO CURB RISING HOSPITAL COSTS WHILE ENSURING THAT MEDICARE BENEFICIARIES RECEIVE HIGH-QUALITY MEDICAL CARE, THE CONGRESS ESTABLISHED THE PEER REVIEW ORGANIZATION (PRO) PROGRAM THROUGH THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982. UNDER THE PROGRAM, WHICH BEGAN OPERATING IN 1984, PROs REVIEW HOSPITAL RECORDS FOR ABOUT ONE-FOURTH OF ALL MEDICARE PATIENT ADMISSIONS. MEDICALLY TRAINED PERSONNEL, USUALLY DOCTORS, REGISTERED NURSES OR ACCREDITED MEDICAL RECORDS TECHNICIANS, SCREEN CASES FOR INSTANCES OF UNNECESSARY OR POOR QUALITY CARE.

WE RELY HEAVILY ON THE PROs TO IDENTIFY PHYSICIANS WHOSE CARE OF MEDICARE BENEFICIARIES MAY NOT MEET QUALITY AND UTILIZATION STANDARDS. GIVEN THE CONTINUING RISE IN THE NUMBER AND COST OF MEDICARE CLAIMS, IT IS IMPERATIVE THAT PROS ACCURATELY SCREEN CASES FOR INSTANCES OF UNNECESSARY OR POOR QUALITY CARE. HOWEVER, WE HAVE UNCOVERED PROBLEMS WITH MEDICARE CONTRACTORS, INCLUDING ONE PRO. THIS IS PARTICULARLY SERIOUS, BECAUSE PROs CARRY OUT GREATLY NEEDED FUNCTIONS TO INSURE THE ACCURACY OF MEDICARE PAYMENTS.

AS PART OF OUR OVERSIGHT AND MONITORING RESPONSIBILITIES, WE HAVE CONDUCTED A NUMBER OF REVIEWS OF THE PRO PROGRAM. I'D LIKE TO SUBMIT THESE FOR THE RECORD.

ROLE OF BENEFICIARIES

SOME MEDICARE FRAUD INVESTIGATIONS BEGIN WITH THE RECEIPT OF A BENEFICIARY'S ALLEGATION THAT MEDICARE WAS BILLED -- AND PAID -- FOR SERVICES THE BENEFICIARY DID NOT RECEIVE OR THAT THE BENEFICIARY RECEIVED THE SERVICE, BUT WAS BILLED TWICE. WHILE NOT ALL BENEFICIARY ALLEGATIONS RECEIVED AND INVESTIGATED BY THE INSPECTOR GENERAL ARE SUBSTANTIATED, MANY HAVE RESULTED IN SIGNIFICANT SAVINGS AND RECOVERIES TO THE GOVERNMENT. HERE ARE SOME EXAMPLES OF THESE CASES.

O WE HAD A CASE INVOLVING TWO NEW YORK CORPORATIONS AND THEIR CO-OWNERS. THIS CASE BEGAN WITH A BENEFICIARY COMPLIANT TO A CONGRESSMAN WHO REFERRED THE COMPLIANT DIRECTLY TO OUR OFFICE. IN THIS CASE, OVER 700 MEDICARE AND MEDICAID CLAIMS FOR SEAT LIFT CHAIRS HAD BEEN FALSIFIED AND $208,000 PAID BASED ON THE FALSE CLAIMS. WE OBTAINED CONVICTIONS AGAINST THE OWNERS ON CHARGES OF SUBMITTING FALSE MEDICARE AND

MEDICAID CLAIMS, CONSPIRACY, AND MAIL FRAUD. RECENTLY, THE CO-OWNERS WERE SENTENCED TO 14 MONTHS AND 3 YEARS, RESPECTIVELY. THE TWO CORPORATIONS HAD TO FORFEIT $340,000, PAY FINES TOTALLING $270,900 AND PAY $10,000 EACH TOWARDS THE COST OF PROSECUTION. AN INVESTIGATION OF OTHER CORPORATE OFFICIALS IS ONGOING.

- BASED ON NUMEROUS BENEFICIARY COMPLAINTS TO THE TEXAS MEDICARE CONTRACTOR, WE INVESTIGATED THE BILLING PRACTICES OF A DME SUPPLIER FOR OSTOMY SUPPLIES. OUR INVESTIGATION FOUND THAT THIS SUPPLIER WAS BILLING CARRIERS IN FLORIDA AND NORTH DAKOTA IN ORDER TO GAIN MAXIMUM REIMBURSEMENT FOR THEIR PRODUCTS. WASHINGTON GROUP INC. (WGI) AND ITS OWNER WERE CHARGED WITH FELONY MEDICARE FRAUD AND SUBSEQUENTLY PLED GUILTY. WGI WAS ORDERED TO RELINQUISH $102,000 IN MEDICARE PAYMENTS HELD IN ESCROW, WAIVE ALL RIGHTS TO APPEAL THE DENIAL OF $800,000 IN MEDICARE CLAIMS, AND PAY A CIVIL MONETARY PENALTY OF $25,000. WGI WAS ALSO EXCLUDED FROM THE MEDICARE AND MEDICAID PROGRAMS FOR 7 YEARS. RECENTLY THE OWNER WAS FINED AN ADDITIONAL $25,000 AND PLACED ON PROBATION.

OTHER OIG ACTIVITIES

CONTRACTOR RESPONSIBILITIES

IN ADDITION TO OUR INVESTIGATIVE ACTIVITIES, WE HAVE ALSO CONDUCTED AUDITS AND INSPECTIONS FOCUSING ON CONTRACTOR PERFORMANCE. THESE ACTIVITIES PROVIDE A USEFUL ASSESSMENT AND HIGHLIGHT DEFICIENCIES AND POTENTIAL VULNERABILITIES. ONCE THESE AREAS HAVE BEEN IDENTIFIED, CORRECTIVE ACTION CAN BE TAKEN. WE HAVE ISSUED SEVERAL REPORTS IN THIS AREA AND, WITH YOUR PERMISSION, WILL SUBMIT THEM FOR THE RECORD.

CONTRACTORS PERFORM TWO PRIMARY FUNCTIONS TO ASSURE THE ACCURACY OF MEDICARE PAYMENTS: CLAIMS PROCESSING AND PAYMENT SAFEGUARD ACTIVITIES. CONTRACTORS ROUTINELY SCREEN CLAIMS TO DETERMINE A BENEFICIARY'S ELIGIBILITY, UNMET DEDUCTIBLE AMOUNTS, WHETHER OR NOT THE SERVICE IS COVERED AS WELL AS IF THE SERVICE IS A MEDICARE-APPROVED CHARGE. IF THE CLAIM PASSES THE CONTRACTOR'S SCREENS, PAYMENT IS MADE LESS ANY UNMET DEDUCTIBLE AND COINSURANCE AMOUNTS; OTHERWISE, IT IS DENIED. A CLAIM IS SUSPENDED WHEN IT IS DETERMINED THAT FURTHER REVIEW IS NEEDED.

THE OIG HAS A RESPONSIBILITY TO MONITOR HCFA AND THEIR CONTRACTORS' PERFORMANCE. IN THE CASE OF PROVIDER FRAUD COMPLAINTS, CONTRACTORS ARE REQUIRED TO REFER TO OUR OFFICE ALLEGATIONS CONCERNING SUSPECTED FRAUD OR ABUSIVE PRACTICES BY HEALTH CARE PROVIDERS WHO HAVE FAILED TO CORRECT DEFICIENT BEHAVIOR.

IN AUGUST 1988, WE ISSUED A REPORT ENTITLED "MEDICARE CARRIERS' PERFORMANCE OF PROGRAM INTEGRITY FUNCTIONS", WHICH FOUND THAT:

- MANY CARRIERS WERE NOT FOLLOWING HCFA POLICIES AND PROCEDURES REGARDING CARRIERS' PAYMENT SAFEGUARD FUNCTIONS; THAT POST-PAYMENT CASES WERE CLOSED WITHOUT MAKING THE NECESSARY CORRECTIONS; AND THAT CASES WHICH SHOULD HAVE BEEN REFERRED TO THE OIG WERE NOT REFERRED.

- BOTH HCFA AND THE CARRIERS PLACED THEIR EMPHASIS ON THE PREPAYMENT REVIEWS AND PLACED A LOW PRIORITY ON IDENTIFYING AND RESOLVING POST-PAYMENT CASES. AS A RESULT, MANY CARRIERS WERE BEHIND IN THEIR REVIEW PROCESS AND WERE NOT RESOLVING CASES WITHIN THE 1-YEAR TIME FRAME REQUIRED BY HCFA.

- OVERALL FUNDING FOR CARRIERS DID NOT APPEAR TO BE A SERIOUS PROBLEM FOR THEIR PAYMENT SAFEGUARD ACTIVITIES AT THAT TIME. HOWEVER, MUCH OF THE FUNDING INTENDED FOR PROGRAM INTEGRITY

FUNCTIONS WAS SPENT ON OPERATIONS NOT RELATED TO IDENTIFICATION AND RESOLUTION OF FRAUD AND ABUSE CASES. WE ARE CONCERNED THAT THIS MAY BE GRADUALLY ERODING THE EFFECTIVENESS OF THE PROGRAM INTEGRITY EFFORT.

WHILE ADDITIONAL IMPROVEMENTS ARE NEEDED, HCFA HAS STRENGTHENED MANY ASPECTS OF THEIR PROGRAM INTEGRITY PROCESS. WE WORKED WITH HCFA TO ISSUE REVISED, DETAILED MANUAL INSTRUCTIONS TO CONTRACTORS ON HOW TO INVESTIGATE CASES OF POTENTIAL FRAUD OR ABUSE. HCFA STRENGTHENED THE CONTRACTOR PERFORMANCE EVALUATION PROGRAM REQUIREMENTS TO ENSURE THAT THE NEW INSTRUCTIONS WERE FULLY IMPLEMENTED AND DOUBLED THE SAMPLE SIZE OF CASES REVIEWED. THE CARRIER'S PERFORMANCE OF FRAUD AND ABUSE ACTIVITIES HAS BEEN SOMEWHAT INCREASED IN THE TOTAL PERFORMANCE EVALUATION PROCESS. IN ADDITION, HCFA REVISED AND STRENGTHENED THEIR POSTPAYMENT REVIEW PROCEDURES. FINALLY, WE COOPERATED WITH HCFA IN SPONSORING A NATIONAL FRAUD AND ABUSE TRAINING CONFERENCE FOR THEIR CONTRACTORS IN 1989. A SECOND CONFERENCE IS SCHEDULED FOR JANUARY 1991.

WE HAVE AN ONGOING PROJECT IN OUR NEW YORK OFFICE ADDRESSING THE MEDICARE CARRIERS' CASE REFERRAL PROCESS. OUR OBJECTIVE IS TO ENHANCE THE QUALITY OF REFERRALS FROM CONTRACTORS TO OUR OFFICE AND TO IMPROVE THE EFFICIENCY OF CASE DEVELOPMENT WORK PERFORMED BY CONTRACTORS. OUR INVESTIGATORS ARE CONDUCTING PERIODIC MEETINGS WITH CARRIER STAFF AND HCFA REGIONAL OFFICE STAFF TO PROVIDE ONGOING CASE DEVELOPMENT TRAINING, COMMUNICATION, AND FEEDBACK ON CASES. WE ARE SPECIFICALLY EMPHASIZING THE PROGRAM INTEGRITY AND MEDICAL REVIEW RESPONSIBILITIES OF THE CARRIERS.

CONCLUSION

AS NATIONWIDE INVESTIGATORS FOR FRAUD AND ABUSE, WE HAVE ATTACKED THE PROBLEM OF MEDICARE FRAUD FROM MANY DIFFERENT ANGLES. PART OF THIS IS DUE TO THE FACT THAT WE NEVER KNOW WHERE MEDICARE FRAUD WILL SURFACE NEXT. IN ADDITION, WE HAVE ATTEMPTED TO BALANCE THE DEPARTMENT'S EFFORTS TO CONTROL MEDICARE EXPENDITURES AND THE INCREASING LEVEL OF FRAUD AGAINST THE COMPETING PRIORITIES AMONG BENEFICIARIES, CONTRACTORS, AND PROVIDERS. OUR RECOMMENDATIONS OVER THE YEARS, BOTH TO CONGRESS AND THE DEPARTMENT, HAVE ATTEMPTED TO TAKE INTO CONSIDERATION THE CONCERNS OF ALL PARTIES.

THIS CONCLUDES MY TESTIMONY. I AM AVAILABLE TO ANSWER YOUR QUESTIONS.

DRAFT

QUALITY ASSURANCE IN INDEPENDENT PHYSIOLOGICAL LABORATORIES

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Richard P. Kusserow
INSPECTOR GENERAL

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OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG) is to promote the efficiency, effectiveness and integrity of programs in the United States Department of Health and Human Services (HHS). It does this by developing methods to detect and prevent fraud, waste and abuse. Created by statute in 1976, the Inspector General keeps both the Secretary and the Congress fully and currently informed about programs or management problems and recommends corrective action. The OIG performs its mission by conducting audits, investigations and inspections with approximately 1,300 staff strategically located around the country.

OFFICE OF EVALUATION AND INSPECTIONS

This report is produced by the Office of Evaluation and Inspections (OEI), one of the three major offices within the OIG. The other two are the Office of Audit Services and the Office of Investigations. OEI conducts inspections which are typically short-term studies designed to determine program effectiveness, efficiency and vulnerability to fraud and abuse.

This study was conducted to assess quality assurance in Independent Physiological Laboratories (IPLs) by examining three aspects of the industry—regulation, personnel qualifications, and equipment standards. The study was prepared under the direction of Joy Quill, Regional Inspector General, Office of Evaluation and Inspections, Region III. Participating in this project were the following people:

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this inspection was to assess quality assurance in Independent Physiological Laboratories (IPLs) by examining three aspects of the industry: regulation, personnel qualifications, and equipment standards.

BACKGROUND

Medicare coverage for IPLs was established in January 1979 when the Health Care Financing Administration's (HCFA) Office of General Counsel (OGC) determined that IPL services qualified for reimbursement under Title XVIII of the Social Security Act. The OGC ruling said IPL services qualify for Medicare Part B reimbursement if (1) the laboratory meets all State and local licensure requirements, (2) the diagnostic services are ordered by a referring physician, and (3) the services are determined to be reasonable and necessary by the Medicare carrier.

Prior to the OGC ruling, HCFA policy disqualified IPLs because they had to be certified for Medicare participation and conditions for participation had not been established. These standards still have not been developed.

The HCFA defines IPLs as " ...laboratories operating independent of a hospital, physician's office, or rural clinic..." Tests IPLs typically conduct include ultrasound, pulmonary function, cardiac monitoring, and a variety of other diagnostic procedures.

METHODOLOGY

The inspection consisted of interviews with four groups: (1) officials of State agencies and health departments, (2) health care and IPL industry experts, (3) a random selection of IPLs, and (4) Medicare carriers.

FINDINGS

Concerns About IPL Performance Are Pervasive

Nearly 78 percent of the respondents who voiced definitive opinions expressed serious concerns about the quality and accuracy of IPL services. The major reason cited for these concerns was lack of regulating IPL operations.

No Assurance Of Satisfactory IPL Performance Exists

We found no uniform and acceptable set of national standards defining satisfactory IPL performance. Contributing factors include lack of (1) oversight of IPL activities, (2) uniform testing standards or quality control measures, and (3) standards regarding operator training and qualifications.

The Definition of "Independent Physiological Laboratory" Requires Clarification

No uniform definition exists of "physiological" as it relates to IPLs. The HCFA has never clarified types of covered IPL tests, acceptable testing sites, or standards and conditions of coverage for each test, thus fostering confusion among IPLs and carriers.

RECOMMENDATIONS

1. The HCFA should promote stronger quality assurance in IPLs through regulation or certification. This could be accomplished through any one or a combination of the following options: (1) Federal regulation, (2) State regulation, or (3) an independent certification program. The cost of such regulation or certification should be financed by provider fees. Elements common to each option include a quality control program, written testing standards, and credentialing staff or equivalent standards.

2. The HCFA should issue Medicare coverage guidelines and instructions clarifying (1) what the term "physiological" means with respect to IPLs, (2) what tests IPLs are allowed to perform to be considered an IPL, and (3) what testing sites are permissible.

INTRODUCTION

BACKGROUND

The Health Care Financing Administration (HCFA) defines independent physiological laboratories (IPLs) " ...as laboratories operating independent of a hospital, physician's office or rural clinic." Prior to January 1979, Medicare did not cover services provided by IPLs. Medicare disqualified IPLs because they lacked certification and conditions for participation of these entities had not been established. Reimbursement was prohibited whether IPLs submitted claims for their services directly to Medicare Part B carriers or the charges were included in physicians' claims.

Coverage was established when the HCFA Office of General Counsel (OGC) determined that IPL services qualified for reimbursement under section 1861(S)(11) of Title XVIII of the Social Security Act. According to the OGC ruling, IPL services qualified for Medicare Part B reimbursement if (1) the laboratory meets all State and local licensure requirements, (2) the diagnostic services are ordered by a referring physician, and (3) the services are determined to be reasonable and necessary by the Medicare carrier.

Typical IPL services include ultrasound, pulmonary function tests, cardiac monitoring, and a variety of other diagnostic procedures. These tests differ from those performed by independent clinical laboratories (ICLs) in that bodily functions are tested (e.g., blood flow, lung capacity, heart rate) rather than bodily fluids or tissues (e.g., blood, urine, Pap smear). The IPL procedures require the patient's presence whereas clinical laboratory tests are performed on a sample taken from the patient. Typically, procedures are performed in a variety of locations including a freestanding center, office space rented from a physician for the conduct of tests, and mobile units.

Ultrasound devices depict a patient's internal organs by sending high-energy sound waves into the body producing echoes as they encounter differences in tissue structures. The data produced by the echoes can be transmitted into an image, which can be shown on a video screen or recorded on tape. Images can be recorded in color as well as black and white. Health care practitioners use ultrasound in a wide range of specialties, such as cardiology, gynecology, and vascular surgery. Typically, the tests are conducted by specially trained individuals known as ultrasonographers or, more commonly, sonographers.

Cardiac monitoring is a diagnostic technique which records a patient's cardiac activity during extended periods of time. This procedure can pinpoint cardiac irregularities, or even a heart attack, of which the patient may not be aware. Cardiac recorders are small, lightweight devices with electrodes fastened to the patient's side. All cardiac activity is recorded on tape which can be evaluated by a cardiologist or sent to an IPL which specializes in cardiac analysis.

Regulation of clinical testing began with Title XVIII of the Social Security Act which imposed standards and conditions of coverage on clinical laboratories under the Medicare and Medicaid programs. In 1967, Congress passed the Clinical Laboratory Improvement Act (CLIA) to regulate the interstate activities of independent clinical laboratories (ICLs). Congress strengthened CLIA in 1988 with amendments which mandated standards in certain kinds of testing. In 1981, Congress passed the Consumer-Patient Radiation Health and Safety Act. This law established minimum standards for State accreditation of radiologic educational programs and State certification or licensure of persons who conducted tests using radiant energy.

No Federal laws exist regulating performing noninvasive physiological testing. Several Federal laws and State statutes have been enacted to regulate clinical and radiant testing. The IPLs which engage in such tests are subject to regulating those aspects of their operations. However, the regulation does not extend to any noninvasive physiological tests conducted by IPLs.

This inspection was originally suggested by the HCFA. They raised concerns about the performance of IPLs because of the lack of regulations and what they perceived as inconsistent practices by carriers regarding IPL operations.

A May 1989 OIG report entitled, "Financial Arrangements Between Physicians and Health Care Businesses" (OAI-12-88-01410), details the effects of physician ownership and compensation arrangements with health care entities, including IPLs. This study indicated that IPLs operated with little or no regulation or standards imposed by either government or the IPL industry itself. As a result, many health care experts and organizations expressed concerns about IPLs and the quality of their diagnostic testing services. Accordingly, we decided to conduct a study focused on regulating IPLs.

During 1987, Medicare paid approximately $260 million in Part B reimbursements for noninvasive diagnostic testing. Although IPLs perform a variety of procedures, three tests—Holter monitoring, abdominal ultrasound, and peripheral vascular studies—accounted for about two-thirds of these reimbursements. In 1987, 1674 IPLs had Medicare provider numbers.

PURPOSE

The objectives of this inspection were

- to determine the nature and extent of regulatory practices regarding IPLs and the services they provide;
- to determine the qualifications of personnel who conduct tests and the perceived effect on testing accuracy if such qualifications appear to be lacking; and
- to assess the integrity of testing in IPLs by examining practices and standards related to physiological equipment.

METHODOLOGY

We conducted interviews with State agency and health department officials, health care and IPL industry experts, a random selection of IPLs, and Medicare carriers.

We interviewed 68 State agency and health department representatives in all 50 States and the District of Columbia. The interviews were designed to elicit the existence of any present or planned State laws affecting IPL operations. In some cases, respondents were unsure of the correct answers to certain questions and referred us to additional agencies in the State.

We conducted 42 interviews with a wide variety of health care experts and organizations. We based selections on their knowledge or interest in the IPL industry. Included among the interviewees were a number of manufacturers of noninvasive diagnostic equipment typically used in IPLs.

Using specially constructed interview guides, we obtained the respondents' opinions, perceptions, and recommendations in such areas as the regulation of IPLs, accreditation of IPL staff, and the efficacy of physiological testing. Health care organizations and associations interviewed included the American College of Cardiology, the American College of Radiology, the Joint Commission on Accreditation of Healthcare Organizations, the National Electrical Manufacturers Association, and the American Institute of Ultrasound in Medicine. (See the appendix for a complete listing of organizations and associations contacted.)

We designed the IPL interviews to ascertain the day-to-day operations of these entities, concentrating on types of diagnostic tests performed, where performed, and kinds of equipment used. Other areas probed included the regulation of their operations by a State or other governmental agency, staff qualifications and training, and quality control practices.

We interviewed 35 IPLs in 8 randomly-selected Medicare carrier service areas. The eight carriers selected were Travelers of Connecticut, Empire Blue Shield of New York, Nationwide of West Virginia, Blue Shield of Florida, Blue Shield of Michigan, Blue Shield of Kansas City, Blue Shield of Arkansas, and Occidental of California. These carriers accounted for approximately 30 percent of total Medicare payments for Part B services in 1986. We also contacted each carrier to determine if it had any special policies to monitor the activities of the IPLs in its coverage area.

FINDINGS AND RECOMMENDATIONS

CONCERNS ABOUT IPL PERFORMANCE ARE PERVASIVE

Interviews with health care experts, IPL operators, and State respondents confirmed that concerns about the quality of IPL services are pervasive. Nearly 78 percent of all respondents surveyed who voiced definitive opinions expressed misgivings about IPL performance. One expert's comment was typical: "Regulation is needed to assure the patient receives quality testing."

Among other reactions received from representatives of health care organizations and associations were:

> *"There should be some standards to protect the public."*
>
> *"It's easy to get false negatives."*
>
> *"Regulation would help to curb improper practices."*
>
> *"You need quality control, and it should be mandatory."*

Owners and operators of IPLs had similar comments. In general, these respondents felt that the lack of regulating IPL operations fostered a climate which allowed some IPLs to skimp on quality control if it suited them to do so. Some of the comments expressed were:

> *"Regulation would stop people who have no regard for quality."*
>
> *"There are lots of bad apples out there."*
>
> *"We need to keep incompetent people out of the business."*
>
> *"Some IPLs have poor techniques. It would not hurt to have some oversight."*

Although quality and accuracy of testing were the concerns most frequently expressed, related issues were also voiced. These issues included safety of testing, reliability of equipment, and qualifications of physicians and staff who operate equipment. Several respondents mentioned potential hazards associated with IPLs who conducted tests using radiation and nuclear medicine.

A number of experts deplored what they perceived as a lack of attention to equipment checks and preventive maintenance. One IPL owner noted, "Some companies use very old equipment." Another interviewee stated, "Doctors generally buy cheap equipment and use poorly trained staff to operate it."

Three respondents were critical of the qualifications of physicians who conducted tests. One expert said, "One-third of all imaging procedures are performed by non-qualified physicians." Another stated, "Doctors should be credentialed in the specialty in which they do testing."

NO ASSURANCE OF SATISFACTORY IPL PERFORMANCE EXISTS

Our study found that no uniform and acceptable set of national standards defining satisfactory IPL performance exists. We base our conclusions on a number of contributing factors: (1) lack of Federal and State regulation of IPL activities, (2) lack of uniform testing standards or quality control measures, and (3) lack of standards on operator training and qualifications. We discuss these factors in further detail below.

Lack of Federal and State Regulation

No Federal laws exist affecting the performance of noninvasive physiological testing; a survey of State survey and licensure representatives found virtually no legislation among the States. Several State respondents indicated their legislatures were considering measures to regulate noninvasive physiological testing.

We also asked State respondents three questions: (1) Should IPLs be regulated? (2) Should IPL staff be certified? (3) Should IPL equipment be subject to mandatory quality control checks? Over 80 percent of those responding answered "yes" to all three questions. One typical comment was: "We regulate barber shops in this State. Why not IPLs?"

As of July 1989, three States (Kentucky, Maryland, and West Virginia) had enacted legislation affecting the performance of noninvasive physiological testing, exclusive of pulmonary function testing. A summary of applicable provisions follows:

- Kentucky — all medical laboratories must be licensed and are subject to periodic inspection. Each laboratory must establish a quality control program acceptable to the State. Personnel qualifications may be prescribed at a later date.

- Maryland — cited elsewhere in this report, the Maryland law regulates equipment rather than facilities. This law regulates only those equipment devices costing more than $600,000, no matter where the testing is conducted.

- West Virginia — similar in most respects to the Kentucky law. However, West Virginia requires that laboratory staff must be licensed and certified.

The only guidelines HCFA has issued regarding IPLs are the provisions relating to service coverage and a prohibition against durable medical equipment (DME) companies from owning IPLs. (This prohibition stems from conflict-of-interest situations in which IPLs were performing oximetry tests for related DME companies. Oximetry test results are needed before oxygen can be prescribed for a Medicare beneficiary.)

Only one of the eight carriers in our survey has a systematic plan for monitoring the IPLs in its service area. This carrier conducts an integrity check on IPL owners before issuing a provider number; after the IPL has been operating for 6 months, a review of their services is automatically scheduled. The other carriers review an IPL's activities only in response to a specific complaint or in reaction to a question arising during processing an IPL's claim.

Two carriers require IPL directors to be physicians. One carrier requires IPL staff to be certified in accordance with local laws.

Lack of Uniform Testing Standards or Quality Control Measures

We conducted interviews with a wide variety of health care organizations and experts representing professional societies aligned with specific forms of diagnostic testing, equipment manufacturers, credentialing organizations, and public interest groups. Thirteen experts said noninvasive physiological testing—no matter where the testing was performed—lacked uniform testing standards or quality control measures.

Ultrasound tests, in particular, were singled out as lacking uniform performance standards or quality control measures. Some typical comments were:

> *"There is no standardized protocol for doing ultrasound tests."*
>
> *"Other than ultrasound, there are fairly well documented quality control procedures."*
>
> *"There is no independent standard that each manufacturer (of ultrasound equipment) can be measured against."*
>
> *"Ultrasound is more of an art than a science."*

Several interviewees blamed the Food and Drug Administration (FDA) for failing to establish standards for ultrasound testing. One expert noted, "FDA has no image quality standards on ultrasound equipment."

The 1976 amendments to the Federal Food, Drug, and Cosmetics Act empowered FDA to regulate medical equipment devices. One of the functions granted FDA was to develop performance standards for new medical devices. The amendments permitted FDA to approve new equipment for marketing without evaluation if the equipment was substantially equivalent to preenactment devices. Presumably, this provision was designed to help FDA cope with the hundreds of devices it receives for evaluation every year.

However, several General Accounting Office studies as well as a recent OIG study, "Home Testing Devices: FDA Clearance and Monitoring Activities" (OAI-12-89-01360), found that, although performance standards for medical devices had not been developed, FDA has safeguards in place to assure the safety and effectiveness of equipment. Primarily, FDA uses its own draft guidance instructions to manufacturers and voluntary standards to evaluate the performance of medical devices.

During the inspection, we encountered a number of examples of performance standards which we considered laudable. For example:

- The American College of Radiology Task Force on Standards Setting developed a 14-point performance standard on mammography testing. Not only does the standard stipulate technical equipment requirements, but it also cites goals, indications, contraindications, frequency guidelines, and qualifications for both technicians and technologists.

- A Maryland law governing equipment costing in excess of $600,000 mandates that every operator of such equipment establish a "Quality Assurance Program" detailing appropriate use and monitoring of the equipment. The Maryland law cites appropriate elements of the Program as including "...documentation of informed consent, checks for allergies, appropriate medical history prior to testing..." The law also requires equipment operators to hold monthly meetings to evaluate identified problems regarding their services.

- A midwestern IPL conducting more than 20 different ultrasound procedures produced an operating manual which details patient preparation procedures, clinical indications, expected results, contraindications, and technical requirements for each test.

Whenever feasible, we obtained copies of written performance guidelines. These guidelines ranged from detailed instructions on how tests were to be conducted to employee leave requests. In no case were these guidelines prepared as a result of State or other regulation. All had been prepared voluntarily. For example, the American College of Cardiology has promulgated standards on a number of diagnostic cardiovascular tests. However, no requirement exists for any IPL to adopt these standards. Clearly, if the IPL felt no compulsion to prepare performance guidelines and standards or adopt existing ones, it did not do so.

As with performance standards, the quality control measures established by the IPLs we contacted were strictly voluntary. If an IPL did not want to implement quality control procedures or special techniques to verify accuracy, it did not do so. All the IPLs we contacted, however, did engage in at least one quality control procedure. The range and extent of such procedures appeared to vary considerably from IPL to IPL.

Lack of Operator Training Standards and Qualifications

Of 17 health care experts who expressed an opinion on this issue, 15 favored minimum educational and training standards and mandatory credentialing for technologists who operate physiological testing equipment. Typical comments were:

> *"Poorly trained, uncredentialed laboratory techs are one of the major problems affecting the quality of physiological testing."*
>
> *"If an IPL had only registered people, it would indicate they are concerned about quality."*
>
> *"If a tech is considered competent, but is not credentialed, then there is something missing in his training."*

Our IPL interviews revealed that 18 out of 45 equipment operators or technologists were neither registered by an accrediting organization nor registry-eligible (meeting all qualifications for registration except passage of an examination). Additionally, 15 of the 35 IPLs contacted did not require their technologists to take continuing education courses annually.

The IPLs are not required to hire registered technologists. With limited exceptions (noted below), no laws or required standards exist denoting minimum educational or training standards for operators of medical equipment devices. The owner of a midwestern IPL stated, "Some IPLs can just drag people off the street and train them. Personnel qualifications should be the same no matter where the test is done—IPL, hospital, or wherever."

Pulmonary function testing is the only noninvasive physiological test subject to extensive regulation. Twenty-four States along with Puerto Rico have legislation requiring pulmonary and respiratory technologists to be licensed by the State in which they practice and certified by the National Board for Respiratory Care, the national credentialing body in that field.

In the two most frequently performed IPL tests—ultrasound and cardiac monitoring — virtually no standards exist regarding training, educational requirements, qualifications, or accreditation. Every IPL is left on its own with respect to staff qualifications and requirements. If an IPL chooses not to establish any qualifications or criteria for its employees, it is free to do so.

While only Utah and West Virginia have laws affecting sonographers (who operate ultrasound equipment), a number of other States are considering legislation. The Utah law, which will become effective April 1991, requires sonographers to be licensed by the State and certified by a nationally recognized credentialing body. The West Virginia law, passed in April 1989, requires all "lab technicians and lab technologists" to be licensed and certified. Although this law mandated implementation in 90 days, a State official advised us that full implementation may be delayed due to monetary problems.

No uniform national standards exist regarding training or qualifications of technicians who do ambulatory electrocardiography (AECG) analysis. Further, no recognized credentialing bodies offer certification examinations in AECG monitoring. One credentialing organization does offer a "self assessment" examination; however, this is offered solely on a voluntary basis.

RECOMMENDATION

The HCFA should promote stronger quality assurance in IPLs through regulation or certification. This recommendation can be accomplished by any one or a combination of the options listed below. However, any proposal addressing quality assurance in IPL services should include these elements: (1) a quality control program, (2) written testing standards, (3) credentialing of staff or equivalent experience and training, (4) a program of continuing education or training, and (5) onsite inspection visits. These elements are implicit in each of the options listed below. The cost of such regulation or certification should be financed by provider fees.

Federal Regulation

The HCFA could seek legislation to impose national certification standards on IPLs along the lines of laws governing ICLs. Such standards would address minimum staff qualifications and training as well as mandatory quality control equipment checks. Periodic onsite inspection visits would be required. These visits could be done by the same State agencies which survey ICLs. Costs could be offset by assessments against the inspected entities. Any IPLs which fail to meet minimum standards would be barred from participating in Medicare. (If merited, these standards also could be extended to physicians who conduct a large number of diagnostic tests in their offices.)

State Regulation

The State of Maryland has implemented a law which regulates all major medical equipment costing more than $600,000. The law calls for licensure of such equipment no matter where it is located, yearly inspections, minimum staff qualifications, and a mandatory quality assurance program. The HCFA could seek national legislation modeled after the Maryland law (using a reduced dollar threshold), with enforcement conducted by each State. Enforcement expenditures could be covered by equipment operator fees. Equipment operators who fail to meet standards would be barred from participating in Medicare.

Independent Certification

In conjunction with industry groups, the HCFA could establish an independent oversight organization to monitor and certify IPLs. (Legislation may be needed to effect this approach.) Certification would be required before an IPL could participate in Medicare. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) favors this approach. According to the JCAHO, IPLs have many characteristics in common with ICLs; many of the standards established for ICLs could also apply to IPLs. The JCAHO standards used for hospital clinical, radiant, and physiological testing could be used as a model for an independent oversight program.

THE DEFINITION OF "INDEPENDENT PHYSIOLOGICAL LABORATORY" IS UNCLEAR.

No uniform definition exists of "physiological" as it relates to IPLs. The HCFA has never clarified types of covered IPL tests, acceptable testing sites, or standards and conditions of coverage of each test. This has fostered confusion among IPLs and carriers.

We encountered a diverse array of entities operating as IPLs. These ranged from large corporations conducting a multitude of diagnostic testing to sole ownership enterprises performing an occasional EKG. Equipment ran the gamut from a $100 blood pressure cuff to almost a million-dollar magnetic resonance imaging (MRI) device. A wide variety of IPL types were categorized by testing sites. Moreover, despite HCFA's definition of an IPL as a laboratory operating "...independent of a hospital, physician's office, or rural health clinic...", we found a number of IPLs conducting tests in hospital settings and in physicians' offices. The HCFA's guidelines provided no direction on *where* the tests could be performed or exactly what was meant by the phrase, "...operating independent...".

On the advice of a medical consultant, we intended to exclude from this study any diagnostic services which were invasive or potentially harmful to a patient. Thus, we proceeded on the basis that invasive and radiant tests, such as blood tests and x-rays, were not "physiological" tests and would not be included in our study. However, we learned that many IPLs were conducting these tests.

In 1979, when OGC determined that IPL services qualified for coverage, the only requirements were the three stipulations referred to previously (see Introduction). In its decision, OGC did not offer a definition of the term, "physiological". It did, however, cite two noninvasive services as examples of the types of tests for which payment could be made: electrocardiographs (EKGs) and electro-encephalograms (EEGs). The OGC opinion further noted, "Carriers shall advise all affected independent laboratories that HCFA is studying the type of services furnished by these independent laboratories and that standards and conditions for coverage of some or all of these services may be published by regulation."

To date, an elaboration of those "standards and conditions" has not been delineated, either in regulations or in HCFA guidelines. As a result, considerable confusion exists with regard to defining an IPL, tests permitted, and IPL qualifications.

One carrier indicated it would issue an IPL provider number to an entity which did clinical and radiant testing. Another said it would attempt to categorize the entity as a physician's office and issue a provider number accordingly.

One carrier had asked its HCFA regional office to clarify the kinds of tests IPLs could perform. The carrier noted that IPLs in its service area were conducting the following tests: doppler flow studies, ultrasounds, EKGs, EEGs, pulmonary function tests, MRIs, and computerized axial tomography (CAT) scans.

The regional office responded that a specific list of such services has never existed, other than the reference to EKGs and EEGs. The response further noted: "The responsibility for defining the tests included has been left to the Medicare carriers. A practical definition might be that any test which is a clinical laboratory or radiological test cannot be considered as a physiological test. To that extent, we would disagree with your inclusion of cat scans as being physiological, since we consider them to be a radiological procedure."

Our study encountered a bewildering variety of entities. Some actual examples:

- One of the IPLs we interviewed conducted ultrasound tests, mammographies, and tests involving nuclear medicine.
- A representative of a chain of diagnostic testing centers advised us that his centers were structured as physicians' offices rather than IPLs to bypass restrictive laws in the States where his centers were located.
- One durable medical equipment company had to obtain an IPL provider number because it occasionally performed EKGs. In 1988, the company had performed only four EKG tests.
- One IPL defied description. It acted as a "middleman," by obtaining physician referrals and contracting them out to an IPL. The company itself maintained no staff or equipment.

In our IPL interviews, we attempted to characterize each IPL according to types of tests performed, testing locations, and physician-directed or not. We classified the types of tests into four categories: (1) one type of noninvasive test only (such as a cardiac monitor), (2) both invasive and noninvasive tests conducted, (3) both radiological and noninvasive tests conducted (such as mammogram and ultrasound), and (4) multiple noninvasive tests (such as ultrasound and pulmonary function).

SUMMARY OF IPL CONTACTS

TYPES OF TESTS	*IPLs*
One type only	15
Invasive & noninvasive	5
Radiological & noninvasive	7
Multiple noninvasive	8
TESTING LOCATIONS	*IPLs*
Stationary	21
Mobile only	6
Mobile & stationary*	5
Hospital settings	3
ORGANIZATION	*IPLs*
Physician-directed	17
Non physician-directed	18

* Includes equipment leased to physicians' offices, tests conducted by IPL staff in leased space, and tests analyzed in IPLs after being performed in physicians' offices.

RECOMMENDATION

The HCFA should issue Medicare coverage guidelines and instructions for IPLs. The instructions should clarify (1) what the term "physiological" means with respect to IPLs, (2) what tests IPLs are allowed to perform to be included in the IPL category, and (3) what testing sites are permissible. These directives will enable carriers to treat IPLs in a more uniform and consistent manner.

APPENDIX

INSPECTION CONTACTS

1. American Association for the Continuity of Care
2. American Association of Retired Persons
3. Acuson, Inc.
4. Advanced Technology Laboratories
5. American Association for Respiratory Care
6. American Association of Medical Assistants
7. American College of Cardiology
8. American College of Radiology
9. American Imaging Association
10. American Institute of Ultrasound in Medicine
11. American Medical Technologists
12. American Registry of Clinical Radiography Technologists
13. American Registry of Diagnostic Medical Sonographers
14. American Society of Echocardiography
15. American Society of Internal Medicine
16. CCI/NBCVT (formerly Cardiovascular Credentialing International/National Board for Cardiovascular Testing)
17. Citech (Center for Information on Technology for Health Care)
18. Center for the Advancement of Ambulatory Monitoring
19. Circadian, Inc.
20. Credentialing Commission
21. Diagnostic Health Services
22. ECRI (formerly Emergency Care Research Institute)
23. Federation of State Medical Boards
24. Food and Drug Administration
25. Health Industry Manufacturers Association
26. Hewlett-Packard
27. Joint Commission on Accreditation of Healthcare Organizations
28. Keith Mauney & Associates
29. Marquette Electronics, Inc.
30. Medical Technology Practice Pattern Institute
31. National Board of Respiratory Care
32. National Commission for Health Certifying Agencies
33. National Electrical Manufacturers Association
34. National Organization for Competency Assurance
35. National Society for Cardiovascular Technologists
36. Nuclear Associates
37. Office of Licensing & Certification Programs, State of Maryland
38. Public Citizen Health Research Group
39. Radiation Measurements, Inc.
40. Society of Diagnostic Medical Sonographers
41. Society of Vascular Technology
42. Ultramed, Inc.

Chairman **Pickle**. Mr. Morey, Ms. Gagel, I appreciate your testimony. Your entire statement will be made a part of the record.

I am also mindful of the statistics and facts that you have given us showing the scope and depth of your involvement and the numerous cases that you have handled, and indeed the fines and the recovery that you have made back into the program. So our committee is impressed with that. We are not holding this hearing to examine each one of those, but we accept your figures as being factual, and they are impressive.

We now want to talk to you about procedure and what is really happening out there in the field and what is probably happening all over the country. I want to ask Mr. Shaw to proceed first to ask questions. Then we will all be asking other questions to you also.

Mr. Shaw, will you proceed first, because it was his district that this particular case was uncovered.

Mr. Shaw.

Mr. **Shaw**. Thank you very much, Mr. Chairman.

I would like to actually take my questions from a letter that you, Mr. Chairman, and the members of this subcommittee signed addressed to Congressman Stark in his position as chairman of the Subcommittee on Health. I would like to get this panel's opinion in the record as to each one of these several suggestions that we have asked the subcommittee to look into.

The first area that we talked about was to consider increased funding for the program safeguards. We found that, in our hearing, it was stated that a $25 million increase in the safeguarding funds could actually result in a savings to the system of $500 million, $25 million would save $500 million. This becomes, I think, particularly pertinent now that one of the areas of the summiteers discussion is substantial cuts in the Medicare area.

Whichever one or all of you would like to address that question, I would like to have a reply to that.

Ms. **Gagel**. I would be pleased to address it. While I cannot speak to certainly the source of those numbers, the payment safeguard funding that the letter refers to is funds that we use, that we provide to Medicare contractors to investigate instances of fraud and abuse, to determine the medical need of claims, to determine the coverage of claims, to perform the audit function at hospitals and skilled nursing facilities, and to determine whether or not Medicare is primary or secondary.

There is no question that at the current level of funding, those activities are extremely cost-effective. The rate of return on average, if you group all three of those activities together is in the vicinity of $10 to $15 for every dollar that is spent.

There is also no question in our minds that additional funding in those areas would maintain that level of return for some time in the foreseeable future. We have not reached the level of diminishing returns, we don't think, in those areas.

Mr. **Shaw**. Were there any other opinions at the table?

Mr. **Morey**. We have noticed over the years that for every dollar we spend in the Office of Investigations, that our return is about 3 to 1; 66 to 1 for the entire OIG. We have also noted that wherever we open a new office with more criminal investigators, that we have more health care convictions. Certainly there are many parts of our country that are inadequately staffed. There is a direct correlation between investigative resources in the health care areas and the amount of moneys returned and the amount of convictions obtained.

Mr. **Shaw**. We also found in Florida that when a complaint is made there is no real acknowledgment of that complaint, that it is looked into and once the complaint is investigated and some type of action is taken or not taken, it is not until then that the person making the complaint receives any acknowledgment of having made that complaint.

It appeared to this subcommittee and to us particularly while we were in Florida that it would be a better procedure to acknowledge, even by a simple postcard, that the complaint had been received and it has been noted and it is being looked into, because of the tremendous time gap between the making of the complaint and the reply. Most people figure they are throwing something into a deep hole that has no bottom and nobody is listening. That I think discourages people from making these type of complaints rather than encouraging it.

That is not a question, but rather a suggestion, unless you want to comment on it.

Ms. **Gagel**. Mr. Shaw, I might say that we agree with you. The vast majority of complaints that come in from beneficiaries do come in over the telephone. So the carriers acknowledged at that time that indeed action will be taken. But, we are in the process of looking at our procedures to see if we want to have more followup with the complainant.

Because clearly the major sources of information about potential fraud and abuse is from beneficiary and provider complaints. We want to encourage these complaints rather than discourage them.

Mr. **Shaw**. Mr. Chairman, there is a vote on the floor. I know that both of you have to go over there.

Chairman **Pickle**. We have a vote on the floor. We have only about 5 minutes to get to the floor. It will be followed by an additional vote. In view of the two pending votes, the Chair will call a recess for 15 minutes.

[Vote recess.]

Chairman **Pickle**. The committee will resume its sitting.

Immediately preceding the vote Mr. Shaw was involved in questioning of the witnesses.

Mr. Shaw.

Mr. **Shaw**. The HHS regional inspector general again referring to the Florida hearings, said his investigation was hampered by the time required to retrieve documents and information from the Medicare carriers. The IG could not commence an investigation and begin interviewing witnesses without obtaining certain information. They estimated it takes on average 225 days after the case is opened before he can get the pertinent information.

I understand that the Health Care Financing Administration and the IG's office have been discussing the idea of giving the IG online access to provider information for some time. However, this has not been done.

Could you first of all comment on your favorable or unfavorable view toward online information, and then if you know, state why it has not been done, and can this be done without legislation?

Ms. **Gagel**. I will be pleased to respond to that. Mr. Simon and I met about 2 weeks ago and we agreed to meet in October to talk about the provision of online access by the inspector general's office to our files. That will start in October with a briefing for his staff by my staff or the new computer system and the data that is in it.

So I think there is an opportunity to do something. Legislation is not required for that.

The other thing that we agreed needed to be looked at was the speed with which Medicare carriers respond to additional development requests from the IG's office. That activity would not be covered by the kind of electronic exchange of information or access to information that you are talking about. We are going to look at those timeliness standards and see if we cannot speed them up a little bit.

Mr. **Shaw**. Do you think that online access is a proper way to go?

Ms. **Gagel**. I think that I need to know a little bit more about the kinds of information that the inspector general's office needs, in order to know whether or not the best way to provide that to him is through online access. I think we already agree in concept. Now, we are talking about now the mechanics of it and what is possible and what is not possible.

Mr. **Shaw**. As far as Blue Cross and Blue Shield of Florida, it has been a very low priority as far as their getting that information up. As I understand, these people are evaluated as to fraud detection as well as other situations. Do you have an evaluation of Blue Cross and Blue Shield of Florida in the area of fraud?

Ms. **Gagel**. Yes, we do. Contractors get evaluated each year. The evaluation for the current year is just now created. I don't have the results.

I might suggest to you that it is not a decision of Blue Cross and Blue Shield of Florida whether or not the inspector general has online access. It is a decision of the HCFA. We are prepared to make that decision.

Mr. **Shaw**. Perhaps you would make that evaluation available to this committee once it is available to you.

Ms. **Gagel**. I will be pleased to do that.

Mr. **Shaw**. Another area we found in Florida, it is often easier to get a provider number than it is to get a VISA or American Express card. Why don't we know something about these people before we hand out these numbers? They are almost like blank checks if you give them to crooks, signed blank checks.

Ms. **Gagel**. In many areas we do obtain information on providers before issuing a provider number. For example, a physician needs to be licensed in order to be paid for services provided to a Medicare beneficiary. We are now developing conditions of participation for their participation in the area of clinical labs, as you know, in the program. That is already the case for hospitals and skilled nursing facilities.

We do not, however, have conditions of participation for durable medical equipment suppliers. Essentially if they are in business under the law then they can receive a provider number. Unless they had been previously excluded from the Medicare program by the inspector general's office, we have no legal authority to deny them access to the program at this point in time.

Mr. **Shaw**. So you would need a statutory fix on that?

Ms. **Gagel**. Yes, that is my understanding.

Mr. **Shaw**. That would be one of our recommendations to the Health Subcommittee. Hopefully we will close that gap by requiring State licensing or whatever. Somebody has to be responsible for who gets these numbers.

We also found an instance where a piece of equipment, called a TENS unit, which is about a $60 item, Medicare has been paying $400. That is another area of great abuse.

We also found that a certificate of medical necessity was not necessary or required for medical reasons for some durable medical equipment, which would seem to be an awful gaping hole and an area of great abuse in the Medicare law or the enforcement of the Medicare law.

A lot of these areas I think by just your own regulations can be tightened up by your procedures.

Ms. **Gagel**. We are doing several things in that area that I think the committee will be pleased with. With regard to the pricing of DME, we are now implementing regional pricing, which was part of the six-point plan passed by the Congress a year or two ago. Beginning January 1, 1991, the prohibition against pricing things in an inherent reasonableness way expires.

So we are engaged right now throughout the country in a process of examining whether or not the prices we are paying for various pieces of DME, including TENS units, are reasonable. Where we feel it is not, we are publishing new prices. That is an ongoing activity. Hopefully you will see more reasonable prices in the near future for durable medical equipment.

We are also requiring certificates of medical necessity for some of the more expensive or more abused durable medical equipment, items such as TENS units, seat lift chairs, and portable oxygen units so that we can assure ourselves, as part of our adjudication process, that this equipment is necessary and was prescribed by the attending physician of the patient.

These are all procedures that we have been putting in place over the last 12 months.

Mr. **Shaw**. Thank you, Mr. Chairman.

I yield back the balance of my time.

Chairman **Pickle**. Thank you, Mr. Shaw.

I want to ask HCFA a series of questions. I may be repeating some of the same general questions Mr. Shaw has asked, but let me proceed. If you have covered, you can point that out.

I want to know what HCFA or Blue Cross and Blue Shield has done about the mobile laboratories involved in the cholesterol scam that took place in Florida. HCFA, now, is supposed to set the regulations under which these kinds of programs would operate. You pass those on to the Blue Cross and Blue Shield.

Our people who were going to be given the free tests in Florida called the Baltimore office and said, we are suspicious, we think something ought to be looked into. They said, well, write us a letter.

Now when you say "write me a letter," the chances are they will not sit down and write a letter; is that correct? Would you agree with that? At least 50-50, it might go either way. If they don't write a letter there is probably nothing done; is that correct?

Ms. GAGEL. I don't know the instance that you are speaking of, but yes, I think that might be possible.

Chairman PICKLE. Well, in the Florida hearings we heard these laboratories involved in the scheme were still in business. Apparently you said to Mr. Shaw a few minutes ago that they are still operating, not handling nearly as many claims, but they are still operating.

Ms. GAGEL. That is my understanding, but I would defer to the IG's office.

Mr. SIMON. They are still operating. There are aspects of their business that are legitimate and they are entitled to remain in business. But that entire operation has really been truncated. Payments have been greatly reduced.

Chairman PICKLE. The program they were operating in this residential center was illegal, as we understand it, and it was proved to be so, why don't you just take away their license or their certificate, can you do that?

Mr. SIMON. They cannot be excluded from the program until they have been convicted of a crime unless there has been an administrative decision that there is a gross quality of care deficiency. Neither of those has occurred yet in this case.

Chairman PICKLE. Ms. Gagel said these people have a certificate to operate and under the law they can continue unless somebody takes that away. Yet your investigation showed that these people were not operating legitimately, if not fraudulently, and therefore you initiated steps, I assume, to vitiate those claims. Have you done that?

Now if you have done that and they are still in business, why do you still do business with a crook?

Mr. SIMON. The investigation that we are conducting, Mr. Chairman, is focused on two illegal activities. One is payment and solicitings of kickbacks to physicians for referrals of patients. That is a criminal investigation involving the Medicare statute.

The other aspect of the investigation is billing for services that have not really been rendered, upcoding is one way of putting it.

As to whether the services they actually provide are medically necessary or not, that is a part of our investigation. But it hinges on whether in fact the doctor has prescribed or directed that those services be rendered that we are on our way to proving as well.

But it is a criminal investigation. It has to be proven beyond a reasonable doubt. An accusation has to be made by a grand jury.

I will say to you that that case has been presented to a Federal grand jury——

Chairman PICKLE. You are talking about a conviction. I am talking about your operation.

Are you with HCFA or with the inspector general?

Mr. SIMON. The inspector general.

Chairman PICKLE. I am not asking you to make an indictment and I am not trying to prejudge the federal system.

You have the power to say we are not going to do business with this agency, do you not?

You have said two of the operators in this so-called scam may be under indictment, but the project as a whole as a scam, violation of good practice—why don't you, if you are empowered, take their license away or just say we are not going to do business with you?

Instead, they are continuing to operate.

It seems you are being too technical, too legal or too fair, saying they have done some good work; but if they have done wrong, they ought to be removed from the practice.

You don't have to indict them. We are saying you don't have to do business with them, yet they are still in operation.

You said you would look into that.

How did Medicare find out about this particular fraud? Would it have been found out if it hadn't been reported directly to Mr. Shaw's office?

Mr. SIMON. I would hope that eventually it would have been, that the carrier would have picked it up for the public and come to us.

Chairman PICKLE. How would it have been uncovered, Mr. Simon?

Mr. SIMON. Possibly through a utilization review.

The carrier could have referred it to us.

Mr. MOREY. It would come into the carrier screens and that would set off the screen and they would notify our offices.

You mentioned how could we stop doing business with these folks.

The only way to do that, is with stationary authorities given by Congress, which says you can sanction health care providers for 5 years if you can convict them.

We would have to put every bill under a microscope that they submit to us to see whether or not it was fraudulent.

Chairman PICKLE. You are saying you don't have authority to tell that group or any group if they have a certificate, we are not going to do business with you?

Mr. MOREY. The sanctioning authority, once they are convicted——

Chairman PICKLE. In the absence of conviction, you are saying you do not have the authority to withhold doing business with them?

Mr. MOREY. I believe that is true.

Ms. GAGEL. Yes.

Unless we are told by the inspector general's office to exclude someone, we cannot do it.

Chairman PICKLE. If this hadn't been reported to Mr. Shaw's office—Mr. Simon said he would hope that eventually we would have detected that. That sounds to be kind of like a forlorn wish and hope, and we agree with that, but there ought to be some way that you would know this practice was going on without somebody specifically reporting it to you and say, "I think these people are crooks."

I understand you have a procedure called peer comparison. Every so often, you make a review of one practitioner as against another.

Those reviews take place, what, every 6 months?

Ms. GAGEL. Quarterly.

Chairman PICKLE. And if you look at them quarterly, you have a chance to catch them.

This was reported to you in August, and yet a year later you are still doing business with these people; 15 months later, at least.

Ms. GAGEL. We are doing business with them, but we have stopped the abuse that Congressman Shaw helped us uncover.

They are not being paid for the kind of services that they were being paid for under this scheme.

Every bill that is sent to Blue Cross and Blue Shield of Florida by these labs is looked at prior to payment and the carrier assures itself that this, indeed, was a needed service that was provided.

Chairman PICKLE. Let me ask you a matter of procedure.

At our Fort Lauderdale hearing, the regional inspector indicated that it took up to 5 months to get documents from the Medicare carrier, Blue Cross and Blue Shield in that area, and he said that actually HCFA was an impediment to getting this information.

I will get to that specifically later.

The inspector general there said he thought it would be helpful if he, the inspector general, had what they called online access to claims information and if he had that, he could go directly into it and get around HCFA, so to speak.

Do you oppose that online access to information?

Ms. GAGEL. No.

We are about to engage in discussions with the inspector general to see whether or not that is something that we can indeed do.

Chairman PICKLE. You say you are fixing to talk to him about it?

Ms. GAGEL. Mr. Simon and I agreed 2 or 3 weeks ago to talk about it.

I agreed to see what they need and whether or not I can provide it.

Chairman PICKLE. You don't have a problem in trying to see if you can work this out?

Ms. GAGEL. No.

Chairman PICKLE. Mr. Schulze.

Mr. SCHULZE. Thank you, Mr. Chairman.

I am somewhat shocked, Mr. Chairman—that you not only have no method of cutting off these crooks, but that you have not come to us or someone else and asked for some power to do so, which kind of infers to me that you don't mind doing business with these people.

Is that incorrect?

Mr. MOREY. Mr. Congressman, we live in a great country. I would love to seize their equipment—a lot of Federal law enforcement agencies have seizure rights. We have none, so I couldn't seize their x ray machines.

Mr. SCHULZE. Could you seize it if their equipment was needed for evidence?

Mr. MOREY. They may be needed for evidence.

Mr. **Schulze**. You don't have power to go in and say, "This is evidence for a fraud case"?

Mr. **Morey**. We do that.

Mr. **Schulze**. Did you do that in this instance?

Mr. **Morey**. Yes.

Mr. **Schulze**. But they are still in business, engaged in fraud. You seize part of their equipment and yet you still do business with them. It seems to me, Mr. Inspector General, that you could put a guy on their doorstep, have somebody there where they do business, saying, "This organization is under investigation for fraud against the U.S. Government."

I realize there are instances when some people like the IRS and others go too far, but here is an example of people who are out and out crooks that we are sort of patting them on the head and saying, "Wait until you get through the courts; wait until the lawyers get all their money and we will think about this thing, that you can't do it anymore."

Mr. Shaw asked for an evaluation of the Florida carrier. I would ask for the same thing for Pennsylvania.

[The Health Care Financing Administration provided the following response:]

In fiscal year 1989, the Contractor Performance Evaluation Program (CPEP) prescribed detailed performance standards to ensure Medicare carriers were conducting a comprehensive and assertive fraud and abuse program within the framework of HCFA instructions. An entire CPEP criterion was devoted solely to carrier fraud and abuse situations, developing potential fraud and abuse cases, ensuring that no payments were made to excluded physicians/suppliers, monitoring participating physician agreement violations, and monitoring nonparticipating physician maximum allowable charge violations. Pennsylvania Blue Shield's (PBS) performance in fiscal year 1989 against fraud and abuse standards was outstanding. PBS achieved the maximum score possible in each and every one of the fraud and abuse standards. In the same year, Blue Cross and Blue Shield of Florida (BCBSF), achieved high scores in the CPEP. In all fraud and abuse standards except one, BCBSF achieved the maximum score possible. In the one where it did not receive the highest score, it received 22.5 points out of a possible 25.

The fiscal year 1990 CPEP was also prescriptive in its requirements for carriers to properly conduct fraud and abuse activities. Though fiscal year 1990 CPEP results will not be available until late December, there are no indications as yet to assume that either PBS's or BCBSF's performance deteriorated in fiscal year 1990.

Mr. **Schulze**. I would like to discuss the so-called Philadelphia project, and I understand a very successful investigation was recently concluded.

I understand that you also found great eagerness on the part of the doctors to reimburse the Federal Government.

Will you briefly describe that case for us?

Mr. **Simon**. There was, as you said, a very extensive project out of our Philadelphia field office where we found that DME providers were paying kickbacks to doctors for referral of patients.

The scheme was so massive in scope that there was no way that hundreds of doctors could be prosecuted in the Federal court system, so a cutoff point was reached.

A determination was made that doctors who received kickbacks up to a set amount of dollars would be dealt with civilly.

Those who went beyond that would be dealt with criminally. After we had analyzed their records, we sent out something like just under 300 letters to physicians saying in effect, we know how much you have received illegally from Medicare.

Mr. **Schulze**. These are doctors below the threshold?

Mr. **Simon**. Yes, indicating that we know how much money you have received from these shady operators.

We have decided to treat it this way. We want you to pay back to the program the dollars plus a punitive amount, and the amazing thing is that within weeks, virtually 100 percent of these doctors sent in checks.

Mr. **Schulze**. Did you spell out the amount or let them determine the amount?

Mr. **Simon**. We spelled out the amount.

Mr. **Schulze**. Are you sure it was adequate?

Mr. **Simon**. Everybody paid, so you wonder if you had left too much on the table.

They paid virtually immediately. Very few—something like seven or eight of these hundreds of doctors even asked for a demonstration of the proof, and there were even one or two doctors who said, "Sure, here is my check. Incidentally, tell me how much I owe for my dealings with the other companies that we didn't even know about."

Mr. **Schulze**. What geographical area did this cover?

Mr. **Simon**. Basically, the whole State of Pennsylvania, but mostly the Philadelphia area.

Mr. **Schulze**. Did any of it slip over to Delaware?

Mr. **Simon**. Yes.

Mr. **Schulze**. So, it is the Delaware Valley area.

What was the background of Brill and Cortesé?

Mr. **Simon**. My recollection is——

Mr. **Schulze**. Weren't they convicted pornographers?

Mr. **Simon**. They were. They were criminals who found a good deal in DME on the street.

It requires no professional competencies.

As Ms. Gagel said, if you are in the business, you can get a provider number.

Mr. **Schulze**. How did you catch them to begin with? How did you get a line on them?

Mr. **Simon**. That escapes me.

I am sorry, Congressman.

Mr. **Schulze**. If you will provide that for us.

[The following was subsequently received:]

Question. Would you describe the Philadelphia Project and its impact on investigations in Florida?

Answer. An elaborate scheme involving four diagnostic laboratories and their two owners was uncovered by a task force, led by the U.S. attorney in Philadelphia, on which OIG participated. Laboratory representatives had approached hundreds of physicians, offering to provide a series of diagnostic tests in exchange for patient referrals and the use of their offices. The labs billed Medicare for the tests and paid the physicians $50 for each patient referral. After the labs and owners had been convicted, the U.S. attorney issued letters to almost 400 physicians who had accepted payments, demanding repayments in settlement of civil liabilities. To date, more than $700,000 has been collected from 331 physicians. The case and its results have received wide publicity, serving as a warning to other medical care providers against engaging in similar illegal activities. The dismantling of the scheme not only meant savings and recoveries for the Medicare program but also ended testing which was of a questionable quality. Experts have stated that the quality was generally poor, largely because the persons administering the tests (which included secretaries and cocktail waitresses) were poorly trained.

We hope to conduct a similar type of investigation in Florida.

Mr. SCHULZE. Approximately how many doctors were involved in the entire investigation?

Mr. SIMON. I believe 330 is the number.

Mr. SCHULZE. Was that below the total number?

Mr. SIMON. That was total.

Mr. SCHULZE. How were the kickbacks structured? Was it on a percentage basis or a dollar——

Mr. SIMON. It was a dollar amount per referral.

Mr. SCHULZE. How much was recovered?

You can provide that if you don't——

Mr. SIMON. In total, after all of the receipts came in, it was a number approaching $900,000.

Mr. SCHULZE. What is the status of the criminal prosecutions now?

Mr. MOREY. A couple have been convicted and there are a couple still pending.

Mr. SIMON. Does this case relate to the Florida situation at all?

Mr. MOREY. They are two different cases.

Mr. SCHULZE. I have to state as I did earlier that I am concerned that if the average citizen wants to find how to report Medicare fraud—I went through all the telephone books locally in the Philadelphia and southeastern Pennsylvania area and there is nothing under Medicare or the inspector general, to report Medicare fraud.

Nothing comes with the checks, nothing comes with the reimbursement.

It seems to me if you are serious about Medicare fraud—every bill I get from the water company and electrical company has a multitude of slips in their telling me how to save electricity, expand my telephone service. If we can't put a little slip there saying, "Here are the things to look for for fraud. Here is the telephone number."

I had my staff call the police department. The police didn't know where to go.

Nobody knows how to report Medicare fraud and that is nobody's fault but yours.

You have to tell people how to report Medicare fraud, when and where to do it.

Chairman PICKLE. The committee will stand in recess for 10 minutes.

[Brief recess.]

Chairman PICKLE. The committee will resume its sitting.

Let me go back to the question of certifying these laboratories. When a lab applies to be certified, to whom do they apply?

Ms. GAGEL. To operate in the Medicare program——

Chairman PICKLE. They apply then to HCFA?

Ms. GAGEL. At the moment, they apply, I think, to the carrier for a provider number in order to come in the program.

Beginning in July of 1991, they will need to apply to the Health Care Financing Administration because they are required to be certified by the Health Care Financing Administration and receive a number from us.

So there is a new set of rules, but they don't take effect——

Chairman PICKLE. As of 1991——

Ms. GAGEL. July.

Chairman PICKLE. They do not apply to your organization or do they apply to somebody else?

Ms. GAGEL. They apply to us. They will have to meet conditions of participation in order to be certified to take part in the Medicare program.

With regard to the quality of services they provide, that has not been the case to date.

Chairman PICKLE. Here is a mobile lab. They have a certificate from somebody. They go somewhere. Where do they go now?

Ms. GAGEL. They receive a provider number.

Chairman PICKLE. That may be a different office on the January, but it is a different office than HCFA in both cases?

Ms. GAGEL. They receive a provider number and they need to meet State licensure and health and safety requirements.

Chairman PICKLE. After January 1, they will have to have a State license approval also?

Ms. GAGEL. No, they have to have that now, sir; in order for them to participate in the program.

What is added in 1991 is a stricter set of standards that are Federal as opposed to State standards that deal directly with the quality of the service that will be provided by these laboratories.

They will be certified and recertified periodically.

Chairman PICKLE. Previously, then, if they had obtained a State license to operate as a mobile lab unit, then all they had to do is call you, HCFA, and you would give them a certificate to practice under Medicare, but previous to that, they had to have a State license.

Is that the previous law?

Ms. GAGEL. Yes, they have to have a State license in order for them to participate in the Medicare program.

Chairman PICKLE. I am told that in some instances HCFA has actually issued a provider number by telephone.

They have called in and talked to them and they have said, "All right, we will send you a provider number," and that you have done it. Is that true?

Ms. GAGEL. I have no information one way or another.

Mr. MOREY. I don't know. I know that it is very easy to get the identification number.

Sometimes if you submit the bill first, you can get the number after you have performed the service; you didn't have to get the number ahead of time.

We have had cases of that.

Chairman PICKLE. I didn't know if you had a new set of regulations as of January 1.

I want you to furnish to me those regulations so we know what they are.

In the Florida case, the Florida Blue Cross and Blue Shield testified to our committee there that although HCFA had recovered some $44 million of erroneous payments in Medicare, it was their opinion that this sum was "skimming the surface."

Do you agree that Medicare is just skimming the surface in these fraud cases?

Mr. **Morey**. I don't know how deep skim goes.

We certainly know there is a lot of fraud out there and I don't know if we know exactly how much of it we have tackled.

We know it addressed a lot of new areas that we are working on improving.

Chairman **Pickle**. I am going to ask another question about funding. I am going to yield to Mr. Shaw temporarily.

We will have to go to the floor for another vote.

Mr. **Shaw**. I just have a couple of questions. One is by way of a suggestion.

You testified as to peer review being done every quarter. There is another review, a utilization review that is done every 6 months. That seems to be one of the problems, and I would say that you ought to have some way to put into your computers when somebody goes over a certain amount of claims in any period that you don't have to wait until the end of the 6 months to find out there are 2,500 claims filed, but that all of a sudden when he meets a certain number that seems to be beyond what is normally expected, that his name automatically pop up and someone start looking at all the claims and seeing if some of this stuff can be stopped.

The 1,400 claims that were processed for Healthy Heart, if their name would have popped up early on you could have started looking at them and seeing that they were doing an exorbitant amount of billing, which almost makes it impossible for any honest provider to be returning that much money and getting that much money in the Federal Government.

Another situation which I think was of greater concern to this committee in Florida was a situation where a company named Omnisonics was called on the carpet in Florida because of some of the shenanigans going on there and Blue Cross and Blue Shield said they were going to audit them and watch every claim for 6 months.

So then they agreed and changed their name to RX Sonics and were given a new provider number.

There has to be a way where some of these providers, when they start getting into trouble, would have to show cause why they shouldn't lose their number.

To get a criminal case to trial in Florida takes an extraordinary amount of time and if you need to actually convict somebody of a crime to take his provider number away, at some point the burden should shift to the provider to show cause why he should get his number back or retain his number.

The subcommittee should look into fine-tuning some legislation to give you more tools to work with out there, because this is absolutely insane.

Why can't you get a utilization review more often than 6 months?

Why do we have to wait 6 months?

Ms. **Gagel**. Congressman, we don't need to wait 6 months. It is done periodically. You need to have a significant enough claims volume.

The standard mode of operation is 6 months. That doesn't mean it shouldn't be done more frequently for a provider who is on your alert list.

Mr. SHAW. When someone goes over a certain dollar amount, automatically a flag comes out and people start looking at the claims that are filed?

Ms. GAGEL. We do have those kinds of flags in the system.

Mr. SHAW. They are not working in Florida.

Ms. GAGEL. With all due respect, 1,400 claims in Florida is like the tip of the iceberg.

We don't have anything in place that is going to tip off on 1,400 bills in a State the size of Florida.

We are looking at that now, a change in his billing patterns from one month or one quarter to the next.

If we see a big change in billing patterns, we have to look and see what is causing that change.

Mr. SHAW. You mentioned that State licenses are required, in Florida there are no State licenses and they are not required.

This is another area we have to look into to require through some type of friendly persuasion to make it a requirement that they do have licensing requirements that we can depend upon.

Thank you, Mr. Chairman.

Chairman PICKLE. Before I leave this laboratory question, I want to be sure you understand you are going to send us a copy of the regulations about certifying.

[A copy of "Medicare, Medicaid and CLIA Programs: Regulations Implementing the Clinical Laboratory Improvements Amendments of 1988" (Fed. Reg. Vol. 55, No. 98, May 21, 1990, pp. 20896–20959), is being retained in the committee files.]

Chairman PICKLE. These new regulations that will come out January 1991, do they pertain to clinical labs?

Ms. GAGEL. Some mobile labs are clinical labs; yes.

Perhaps all of them are. They may be.

A clinical lab can be mobile or stationary. Whether or not it is clinical depends on the kind of tests that they do.

Chairman PICKLE. Why would it apply in some instances and not in others?

Ms. GAGEL. Whether or not you are a clinical lab depends on the kinds of tests that you do.

Chairman PICKLE. Taking cholesterol tests, is that a clinical lab?

Ms. GAGEL. I am told that, yes, Mr. Chairman, it would be covered.

I would have to provide you, Mr. Chairman, with information about the kinds of services specifically that are covered by the clinical labs.

[The following was subsequently received:]

A clinical lab is defined by law as any facility which performs "biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or assessment of the health of, human beings." In other words, any laboratory which performs tests on human specimens, regardless of its location and whether it participates in Medicare or Medicaid, must comply with the requirements of CLIA 88.

The proposed regulations are based on a complexity model. This means that the level of regulation is based on the test complexity and risk factors related to erroneous results. The actual location of the laboratory does not determine the degree to which it is regulated.

There are three categories of tests: waiver, level I, and level II. A laboratory performing only waiver tests would be required to apply for a certificate of waiver and it must permit unannounced inspections by the Department of Health and Human Services. Under waiver, these labs would not have to comply with any quality control, proficiency testing, or personnel requirements.

A laboratory performing level I tests (including cholesterol screening) is subject to personnel, proficiency testing, and quality control requirements. The laboratory director must have a doctoral degree and assure that tests are properly performed, recorded, and reported. An individual performing level I tests must have at least a high school diploma and adequate training to perform the tests.

Laboratories performing level II tests face much stricter requirements for personnel, quality control, and proficiency testing. For example, an individual performing level II tests must be a qualified technologist or technician.

This proposed rule was published on May 21, 1990 with an extended comment period which closed September 21, 1990. We have received over 44,000 comments. We are in the process of analyzing these comments. As a result, we note that the provisions of the regulation are subject to change.

Chairman PICKLE. More specifically, would these kinds of mobile labs we are talking about in this instance be covered under your new proposed regulations?

Ms. GAGEL. Yes.

Chairman PICKLE. Give us that in writing.

Ms. GAGEL. It is now a proposed regulation.

I will provide you with the proposed regulation.

Chairman PICKLE. Some of the beneficiaries tell us that they would be able to help detect persons who might be involved in fraud if they could better understand the forms that you send them to fill out, forms for benefits.

They are very confusing and they are long and complex. There is a need they say to simplify the forms.

Are you working on doing that?

Ms. GAGEL. We are.

Chairman PICKLE. How far along are you?

Ms. GAGEL. We have a new form and we hope very soon to test the readability and the understandability of that form with focus groups of Medicare beneficiaries.

We would hope to have the form completely redesigned and printed by July of 1991.

Chairman PICKLE. Why would you—we are always trying to oversimplify these things, but why would it take between now and July 1991 to approve a new form?

Ms. GAGEL. Because the form needs to be approved by the OMB. To get a form approved, Mr. Chairman, is a fairly long process.

Chairman PICKLE. Are you saying it takes a year to get a form approved?

Ms. GAGEL. It certainly has been known to take a year; yes, sir.

Chairman PICKLE. Do the best you can as quickly as you can.

I understand that HCFA reimburses Medicare carriers on the basis of what is called per claim; in other words, the more claims in process, the more payments you are going to have.

That is an incentive, it seems to me, that these claims should be processed quickly and you just pay the money out as quickly as possible and then you might look into the question later of whether it is a proper payment or not.

Is that an apt description or an unfair description?

Ms. GAGEL. That is not completely accurate.

By law, the Medicare contractors are paid their costs of administering the program.

The more bills you have to process, the higher your payment will be because clearly, it costs more money to process more bills.

Chairman PICKLE. We are getting short on time.

I have the feeling that—one of our members has said that HCFA is really just a group of money-shovelers; that is, you have got so many claims that on the surface look like legitimate operators and you are under the gun to get those payments out as quickly as you can; and you do it, the forms you have are no big help to detect fraud and you pay them quickly and check later to see has there been any fraud.

The problem is if that is the case, then we pay out millions of dollars and then later say, "I wonder if we could have paid that one." You are under the catch-22—if you go too slow, you hurt people who ought to be reimbursed.

If you move too fast, you are maybe paying a crook.

It is a serious problem.

Ms. GAGEL. If I could respond to that, we have extensive audits in our claims processing systems. In part B, we deny or down-code 18.5 percent of all bills that we receive.

That has been a fairly consistent figure over the years because we do have extensive prepayment audits and screens in the systems to protect the Medicare program. That is clearly our responsibility.

We also have a responsibility to pay the bills in a timely manner, so we attempt to balance those responsibilities as best we can.

Chairman PICKLE. I thank you.

The committee will stand in recess for 10 minutes.

[Brief recess.]

Chairman PICKLE. The committee will resume its consideration of this measure.

The procedure called payment safeguard activity, I assume, means that the Medicare carrier asserts that false or inappropriate claims are not paid.

Medicare claims have been growing in the past 7 years at the rate of about 12 percent, yet I am advised that the funding for payment safeguard activity has been decreased.

Can you tell me by how much payment safeguard activities were cut in 1990?

Ms. GAGEL. Yes, sir.

They were cut from $357 million in 1989, which is the amount that was actually spent by Medicare contractors, to $332 million in fiscal year 1990; the current fiscal year.

Chairman PICKLE. That would be nearly $25 million roughly.

Have you asked that those funds be restored? Did you ask that the funds be restored?

Ms. GAGEL. We requested in 1990 that some of the Medicare contingency fund be released in part for some of these payment safeguard activities and we were successful in receiving $6 million a few weeks ago.

Chairman **Pickle**. You didn't ask for the payment safeguard program specifically being increased about 25——

Ms. **Gagel**. No, sir.

Chairman **Pickle**. Is that correct?

Ms. **Gagel**. Yes, we did not.

Chairman **Pickle**. Can you tell me how many nurse reviewer positions were lost as a result of these cuts?

Ms. **Gagel**. I think approximately 200.

Chairman **Pickle**. So you lost about 200 of those.

All right.

Do you know how many overpayments resulted because of these cuts?

Ms. **Gagel**. No, sir; I do not.

Chairman **Pickle**. Can you furnish that to us?

Ms. **Gagel**. I don't believe there is any way of determining that, sir.

Chairman **Pickle**. My staff tells me that they think it is around $500 million.

Is that too much?

Ms. **Gagel**. I have no way of knowing that, sir.

Chairman **Pickle**. You could estimate.

If you know you lost 200 positions and they had a million dollars—we need to know a guess or some estimation, so please give us that information.

[The following was subsequently received:]

MEDICARE PROGRAM PAYMENT SAFEGUARD SAVINGS RATIO

[Dollars spent: approximate dollars saved]

	Fiscal year		
	1989	1990 [1]	1991 [1]
Medicare review/Utilization review	1:6	1:6	1:6
Medicare secondary payor	1:31	1:39	1:38
Audit	1:6	1:5	1:6
Total [2]	1:11	1:11	1:11

[1] Based on budget projections.

[2] Based on total dollars spent not average of the above ratios.

In fiscal year 1990, it is true that budget constraints forced us to reduce funding in certain areas. As a result, under part A approximately 200 nurse reviewers positions were eliminated. However, we believe that any losses incurred from this reduction in staff was offset by changes we made in the way we administer part A medical review. Although we cannot be certain, we estimate that for fiscal year 1990, we saved roughly $12 million less than the previous fiscal year.

Chairman **Pickle**. Now, because of these cutbacks in medical reviews or utilization reviews, the GAO has told us there has been a serious deterioration in the Medicare contractor's ability to ensure the accuracy of payments.

Do you agree with GAO?

Ms. **Gagel**. No, sir; I do not.

Chairman PICKLE. Here is a Government—an arm of Government, utilized by the Congress asking you to make an estimate as to how much we are losing in these programs in fraud, and they estimate here now of—that you are just barely touching it and you disagree and I can understand why.

Somebody says we are losing an awful lot of money. It seems to me we are going to have to ask further questions about it.

Here the summiteers are meeting and they may or may not get a budget, but we are going to have to come up with something, and I have a feeling if you cut $25 million on these programs last year, you may be asked to cut more.

Do you anticipate how much more you might cut and where, Ms. Gagel?

Ms. GAGEL. I am sorry—in the Medicare contractor budget?

Chairman PICKLE. Yes.

Ms. GAGEL. For 1991—I have, unfortunately, contingency plans for a 32.4 percent cut if sequestration happens.

Those cuts will have severe ramifications on the operation of the Medicare program in this country—severe.

Chairman PICKLE. I don't know that I have got an answer for you because I don't even know what we are going to do about the budget.

I know that based on my figures that you have a contingency fund in your budget now and that fund is supposed to handle unanticipated claims.

Now, I understand that the contingency fund has grown in size from $20 million up to $173 million.

In fiscal year 1988, about $48 million was released from the contingency fund.

Do you know what for?

Ms. GAGEL. That would have been, I assume, for a workload increase during that year; yes.

Chairman PICKLE. In 1989, HCFA requested the release of $90 million. Was it for this program, or do you know?

Ms. GAGEL. It was for Medicare contractor operations, Mr. Chairman.

Chairman PICKLE. Not just this type of program, but for the whole business—and OMB denied it.

Do you know why?

Ms. GAGEL. No, sir. I believe they felt we didn't——

Chairman PICKLE. Just being OMB?

Ms. GAGEL. I wouldn't want to say that, sir.

Chairman PICKLE. Mr. Jacobs?

Let me yield to Mr. Jacobs.

Mr. JACOBS. I don't have any questions.

Chairman PICKLE. I see.

Do you think there is unnecessary operations in cataract surgeries?

Ms. GAGEL. I am not—I don't have responsibility for that area and I am, therefore not in a position to answer that question.

Chairman PICKLE. Let me give you this question—for 10 surgical procedures which were believed to have been performed and not always necessary, the Congress authorized the PRO to perform a 100 percent preprocedure review.

This preprocedure review has indicated that about 0.8 percent of cataract surgeries are unnecessary.

Do you agree with that figure or do you have any idea?

Ms. GAGEL. The peer review organizations do indeed prior approve all cataract surgery in this country.

Their denial rate, I understand, is very, very small, but they do prior approve each of those surgeries.

Chairman PICKLE. The chairman of our Health Subcommittee held a hearing on this point and we have information on it.

It continues to be a serious problem for us.

One last question—in the Fort Lauderdale case, the subcommittee heard testimony about TENS, transcutaneous electrical nerve stimulator, that they were being paid on the cost of that particular machine on the basis that that machine costs $500 to $1,000.

We were advised there that that machine fully could be put together with a few parts from Radio Shack for about $50.

Are these machines effective? Are they doing the job? Do you recommend continued payment under the TENS approach?

Ms. GAGEL. It is my understanding—and I am not a medical doctor—that in some situations those machines are very, very effective.

There is also no question that that is a highly abused area in Medicare.

One of the things that we have done is to institute a process that basically every Me~~dicare b~~eneficiary who is prescribed a TENS unit has a 30-day free trial period to see if the unit benefits the patients.

Then the physician has to certify to the continued medical need and effectiveness. If it is not proved to be of benefit to the patient, it is not ordered and paid for by Medicare.

Chairman PICKLE. You have a schedule based on this particular machine and your estimated cost.

I assume it takes a great deal to change that procedure.

Are you looking at the procedure you have established to see whether these payments are in order?

Ms. GAGEL. We are looking at the pricing of TENS units every unit that is prescribed in the country is reviewed on a prepayment basis.

Chairman PICKLE. Are there others besides TENS that are under consideration at this time, too?

Ms. GAGEL. Certainly, sir.

Chairman PICKLE. What are some types of them?

Ms. GAGEL. Seat lift chairs is the primary example where we review, on a prepayment basis, each of the seat lift chair claims that we have to see if indeed the attending physician has prescribed that chair for the Medicare beneficiary.

Chairman PICKLE. Maybe I ought to ask that of the inspector general.

Are you familiar with these that are under investigation or that you are reviewing?

Mr. MOREY. Yes, Congressman.

We have had several cases especially with TENS, seat lift chairs, but there are other items that equally concern us.

If you take a look at them from what they cost the supplier versus the reimbursement amount from HCFA, certainly you would question why that was occurring.

If you are interested, I could give you some examples of that.

Chairman PICKLE. Yes, I want some examples. What other types of instruments like these TENS also should be suspect?

Mr. MOREY. Like a knee brace, the cost to a supplier was $24. Medicare would reimburse that at about $40. So that seemed reasonable to us. Here is one for a flotation pad for a wheelchair cushion. According to the supplier's cost it was only $8 but HCFA reimbursed at about $248. So that was the type of errors that bring to our attention a possible problem.

Electronic hospital bed, to the supplier the cost is $647. HCFA reimbursed it through Medicare at $1,632, approximately two and a half times what the supplier's cost would be.

I have several others that would indicate that there might be some inequities.

Chairman PICKLE. Will you submit to this committee, the other type of items that you are looking at similar to these types?

Mr. MOREY. Yes, sir.

[The following was subsequently received:]

ITEM (A)	SUPPLIER'S COST (B)	AMOUNT BILLED TO MEDICARE (C)	AMOUNT PAID BY MEDICARE (D)
COMMODE CHAIR	$28.00	$195.00 SALE $50.00 RENT	$94.50 SALE $22.82 RENT
DECUBITOS CARE MATTRESS	$40.00	$700.00 SALE $100.00 RENT	$434.95 SALE $48.41 RENT
FLOTATION PAD (WHEELCHAIR CUSHION)	$8.00	$385.00 SALE $85.00 RENT	$248.96 SALE $59.20 RENT
MOIST ELECTRIC HEATING PAD	$7.97	$75.00 SALE	$53.03 SALE
TOTAL ELECTRIC HOSPITAL BED	$647.00	$3,100.00 SALE $260.00 RENT	$1,632.70 SALE $160.00 RENT
KNEE BRACE (1)	$23.83	$125.00 SALE	$39.17 SALE
KNEE BRACE (2)	$12.40	$75.00 SALE	$23.36 SALE
LUMBO-SPIRAL ORTHOSIS BACK BRACE	$19.10	$130.00 SALE	$71.52 SALE
PARAFFIN WAX BATH	$78.95	$250.00 SALE $60.00 RENT	$183.22 SALE $34.58 RENT
4-LEAD TENS UNIT	$49.90	$750.00 SALE $150.00 RENT	$452.00 SALE $39.46 RENT
LIGHTWEIGHT WHEELCHAIR	$256.00	$1,800.00 SALE $175.00 RENT	$864.59 SALE $70.18 RENT

VARIOUS CASES

ITEM (A)	SUPPLIER'S COST (B)	AMOUNT BILLED TO MEDICARE (C)	AMOUNT PAID BY MEDICARE (D)
SEAT LIFT CHAIR	$280.00	$949.00	$881.00 (QCH
TENS	$93.00	$650.00-$700.00	$472.83 (S.
CATHETER CARE KIT (TOWELETTE, SPONGE, PLASTIC BAG, GLOVE)	$0.46	$3.60	UNCERTAIN (WCI
OSTOMY SUPPLIES (3 BOXES STOMA ADHESIVE WAFERS) --PLUS 1 BOX OF OSTOMY POUCHES	$54.00 $35.26	$364.60	$272.39
HOME INFUSION THERAPY PRODUCTS			
o CHEMOTHERAPY SOLUTION FOR SOME CANCERS (5 DOSES)	$2.95	$1,185.00-$2,000.00	UNKNOWN
o TPN SOLUTION (1 1/2 LITERS)	$30.00	$300.00-$687.00	UNKNOWN
o ANTIBIOTIC SOLUTION (2 GRAMS)	$24.00	$185.00-$200.00	UNKNOWN

Chairman **Pickle**. I assume that this is in the area of durable medical equipment primarily, correct?

Mr. **Morey**. Yes, sir.

Chairman **Pickle**. That is an area under close review now?

Mr. **Morey**. Yes, sir. We have had a lot of DME cases.

Chairman **Pickle**. I noticed a lot of your testimony centered around that.

Can you stay for an additional series of question? We have one more vote. I have a few questions for you, Mr. Inspector General. We will ask you to stay here for an additional 10 minutes. Is that agreeable?

[Recess.]

Chairman **Pickle**. The committee will come to order.

Mr. Morey, tell me, who is responsible for bringing criminal charges in case you wish to bring them?

Mr. **Morey**. The U.S. Attorneys Office in the Department of Justice. We investigate the cases and then we present them to the U.S. Attorneys Office.

Chairman **Pickle**. Do you have any difficulty getting the Department of Justice to bring charges against Medicare cheaters?

Mr. **Morey**. I would say generally no. There are a few parts of the country where health care cases are not the priority but generally across the Nation we have fairly good success rates.

Chairman **Pickle**. Are criminal Medicare charges a high priority with the Justice Department?

Mr. **Morey**. At one time it was one of the top three, I would say Justice is unsure, whether or not it still belongs at that level. But I would say honestly that the Department of Justice has treated health care matters well.

Chairman **Pickle**. How many criminal cases were prosecuted last year by the Justice Department?

Mr. **Morey**. I know how many they prosecuted for us, 155. I am sure the FBI had some health care convictions.

Chairman **Pickle**. You had 155 last year?

Mr. **Morey**. Yes, sir.

Chairman **Pickle**. Is that a small number?

Mr. **Morey**. Compared to maybe 8 years ago when we had 30 a year, it has been accelerating ever since. I would say that is quite aggressive. Next year I know we will have more than that, I guess somewhere around 200.

Chairman **Pickle**. GAO said to us that you, the inspector general and HCFA have just skimmed the surface of the fraud going on out there. Do you agree with that?

Mr. **Morey**. I think that is probably true, Mr. Chairman. We have more expertise this year than we did last year. We get better referrals than we have in the past. I think we will do a better job tomorrow.

Chairman **Pickle**. Well, you said in some respects they had been very aggressive at Justice.

Mr. **Morey**. Yes, sir.

Chairman **Pickle**. Yet, you said next year they will be more aggressive. Does that mean you are going to be more aggressive, the inspector general's office?

Mr. **Morey**. I am not sure we can be too much more aggressive. A lot of our agents have the maximum number of cases that they can handle. For example, a case in Miami might be hard to get prosecuted because of the drug problems in that city. The same case in another State would be readily accepted for prosecution.

Generally, health care cases are very difficult for the investigator to investigate as well as difficult to get the U.S. attorneys' office to understand and feel good about prosecuting these cases.

So it takes a lot of documentation and a lot of expertise to get them to agree to prosecute a case.

Chairman **Pickle**. You are saying you have about maxed out because you don't have enough personnel to follow through on these cases. So under your present budget allotment, with the money to use for preparing the cases, you don't think you can handle much more under your present personnel level?

Mr. **Morey**. I think that is true, Mr. Chairman, especially when you look at our sanctions, not only do we investigate the cases criminally but our sanctions have risen from about 50 to 900. That is a lot of sanctions. That is a lot of paperwork and a lot of other cases that we investigate besides in the criminal area.

Chairman **Pickle**. This committee had no business telling you to sue a lot of people, it ought to be based on facts, based on cases you prepare well, cases you think you can win of flagrant violations. It worries us that we have a program that pays out over $100 billion in funds. Our own Government says we are hardly laying a glove on them, skimming the surface, and you are telling us you don't think you can do more than you are doing.

Do you need more personnel to do it?

Mr. **Morey**. Yes, sir, I think that is true. More resources would be helpful to us.

Chairman **Pickle**. Now, that is a kind of a weak way to put it, you can probably use more help. Do you want more personnel in your division?

Mr. **Morey**. Absolutely. I want to make a positive statement.

Chairman **Pickle**. Do you request it and does HCFA say you can't ask for it or does the administration and OMB refuse to do it because of the budget?

Mr. **Morey**. I think both of those are true. I think we need a lot of people but the budget will only allow us to have a few.

Chairman **Pickle**. Well, it seems to me that we need more specific recommendations. I think through all of this it bothers me that we have a problem in the certification of these laboratories. Now it is a problem. You say they are supposed to be licensed first by the State. In some States that is not required. I don't even know whether it is required in Florida or not.

So, if you say they are supposed to have a State license first, that doesn't really answer the question. Do they or don't they have a license or should they or shouldn't they? We ought to get a recommendation from you so we can see what we can do about it.

If you need more authority and personnel, you ought to let us know. If you need the simple forms, I don't think you need our approval on it but we ought to be getting more recommendations from you. As it is, until one of these cases gets exposed through the press, we don't find out there are a lot of loopholes to be closed, and you don't tell us until the spotlight is turned. It looks like you are asleep at the wheel and don't know what is going on, but you do know but the truth is that we don't know.

I think the Congress can be accused of not giving you enough help in some areas. But we need you to tell us what it is. Unless you give it to us, then it is going to be smeared across the paper and we all look bad.

Mr. Shaw.

Mr. **SHAW**. Mr. Chairman, it appears to me, in the full committee I remember the passage of a bill that proposed to deal with the doctors dealing with themselves, in other words, a wholly owned lab. We put severe restrictions on that. It seems to me that by putting a little more information on the sheet you can establish a case where, when the doctor is sitting in the lab looking at the cholesterol results and sending a person behind a screen next to him for a test, it seems that you could devise a form where that would have to be disclosed and were it not disclosed, that would become fraud itself.

There has to be 1,000 ways to tighten this up. I think the system needs to be changed. It might be a legislative fix but in-house there are a lot of things you can do. The spirit of the law that this Congress passed with regard to self-dealing, there is no way in the world, in my opinion, where we could not provide that the doctor could not be sitting in the laboratory telling somebody to get on the table and undergo a test some feet from where he is standing.

This is crazy. I don't understand it. What can you do about getting this type of information available to you, particularly on the mobile labs? I am sure it is at the stationary labs too, but the mobile labs seem to be the problem we are having now. Why don't we cut them off? Why allow them to go with a doctor sitting in the laboratory providing these tests? This is nuts, why not say you cannot do that?

Ms. **GAGEL**. The physician ownership of labs provision that you referred to has an effective date of January 1, 1992. We are gearing up now to implement that provision.

That will require the physician to disclose to the Government and to the Medicare carrier the extent of his ownership in a lab. If he fails to so disclose, we can deny the bill.

Mr. **SHAW**. Why don't you also require him to disclose any contractual agreement that he has with the lab, however it is? I think for him to be on the premises in the lab in itself, I mean that just stinks from the very beginning.

Ms. **GAGEL**. Congressman, there are numerous labs in physicians' offices around this country. That is clearly one of the ways of doing business, if you will, these days. It is my understanding that simply proximity may not be a problem but clearly financial interest in the lab happens.

Mr. **SHAW**. If I own the lab and I hire people to refer people to me, that should be a prima facie evidence of a real problem. I don't know why you by regulations or we by statute cannot fix that in a heart beat and shout this stuff down.

Ms. **GAGEL**. I know that would require a statutory change.

Mr. SHAW. Well, perhaps, Mr. Chairman, our subcommittee should maybe amend our letter to Mr. Stark in the Health Subcommittee telling him to cut this out.

I cannot think of any legitimate reason for the doctor to be sitting in a lab, just like putting cattle through a shoot saying you get on that table, you get on that table, you need this and you need that, just sitting there as a feeder to the lab to turn in fat bills to Medicare.

I think it should be prohibited. I think we can handle that statutorily. I am all for giving you more inspectors. I think not only in this area, but all across the board you need more. That is money well invested in terms of stopping this fraud. But there are some common sense things that we ought to do.

I don't mean to be critical because I know you all have a hard job out there. But really, it disappoints me that you are not coming to the Congress and saying here is a problem, we brain stormed it in-house, we see a solution, let's get a bill. I think anybody on the Ways and Means Committee would be very proud to sponsor that type of legislation, particularly with the backing of the administration to get at, seek out, stop and stamp out fraud.

I can assure you that this Member would and certainly the chairman and the members of this subcommittee who have listened to this very bizarre type of testimony that we have heard on this subject down in Florida, to find out people are actually getting away with this stuff. It is just nuts.

One of you made an observation that you cannot prosecute a case in south Florida. I can understand that. We are up to our eyebrows in drug cases and violent crimes. The U.S. Attorneys Office is overworked. But that doesn't mean he should not make a priority of at least busting a few people to make an example.

We have to find better ways to do it. Within the system I think you have to have certain alarms going off in certain areas to start paying attention to certain people and analyzing their cases. Go out and talk to some of the people, make some house calls. Talk to the elder folks who have gotten the care. When you see all the people coming in from the same neighborhood, you know what they are up to, they are going to the churches, the senior centers, the condominiums and people think they are getting something for nothing. They fall for it.

But as more and more people learn how to defraud the system it is going to be worse and worse. I think we have to come up with some legislative packages to try to stop as much of it as we can and put safeguards in place to catch these people. I think the Congress owes you the courtesy of adequately staffing your personnel to stamp out this fraud.

Thank you.

Chairman PICKLE. What are the areas where you think Medicare fraud most often occurs?

Mr. MOREY. Do you mean like a DME supplier, are you talking about types of fraud?

Chairman PICKLE. In any area.

Mr. MOREY. Well, certainly we have services not rendered, that is probably one of the biggest offenses that we find where we have a bill for a service that is not rendered, whether or not that is unbundling to get more money or they bundle it up to get to a DRG to allow them to make more money.

Services not rendered is the biggest category.

Chairman **Pickle**. How widespread are the free testing schemes as used in Fort Lauderdale?

Mr. **Morey**. In California we have had mobile lab frauds that were similar to it but other than that and the one in Florida, they are the only ones that I know of.

Chairman **Pickle**. It seems to me every few years we have a hearing about mobile labs. This same subcommittee had one 5 or 6 years ago. It seems to be a recurring problem. I think we need to get some recommendations from the committee, from you or from whatever source, about how to better control mobile labs. On the one hand I can see how the mobile lab could be helpful to a community where the individual would not want to travel long distances, in rural areas, it is accessible and easy for them to go to the mobile labs.

Yet, invariably, it seems like we have more cases of fraud with respect to those kind of operations in connection with durable equipment quite often. So that seems to be a problem area where a lot needs to be done.

Mr. **Morey**. We mentioned Medicaid and Medicare. But certainly the private sector of the insurance companies have the same problem with mobile labs. They have brought to our attention that they have excessive billings there.

Chairman **Pickle**. I am sure they do have. It stands to reason that they would have the same problem.

Now the regional inspector general testified at the Fort Lauderdale hearing and he stated that sometime ago the inspector general's office sent HCFA a report about "significant problems caused by HCFA of uniformity in the assignment of provider numbers."

What are those problems? What did you say to them about the problems where something ought to be done? Can you identify the problem?

Mr. **Morey**. Just the generic problem that provider numbers have also been easily accessible to the provider community. In our opinion, we would like background information on who is asking for the provider number. It would allow us to see who the individual is and give us a starting point.

Chairman **Pickle**. Is it your recommendation that it be made much more difficult to get a certificate?

Mr. **Morey**. Certainly that is our recommendation that the provider numbers be tightened up and there be a lot of information given.

Chairman **Pickle**. To whom have you made that recommendation?

Mr. **Morey**. Well, certainly to HCFA.

Chairman **Pickle**. HCFA, do you agree?

Ms. **Gagel**. I do believe it is as tight as it can be under the current law. I can provide you with information on the criteria that we use to provide provider numbers now for all provider types, if you would like.

I can compare that to the statutory authority for doing so and the authority that we have for withholding a number.

[The following was subsequently received:]

Provider Numbers

There are no regulatory or statutory definitions for provider numbers.

For physicians, when a new physician files an application for a provider number, he must submit certain information to the carrier, such as State license and license number, credentials, graduate medical school and board certification status, previous practice in another State and group practice if appropriate.

The carrier must verify State licensure with the appropriate State licensing board and physician status for prior practices with the carrier serving the prior practice. They must also verify that the physician has not been sanctioned by checking the Medicare/Medicaid Sanction Reinstatement Report issued by the Office of the Inspector General.

The carrier then forwards the information to the Unique Physician Indentification Number (UPIN) registry where it is matched with an American Medical Association masterfile to corroborate the physician's identity. The carrier then issues a provider number and UPIN to the physician.

The inability of the UPIN registry to determine a match does not prohibit the carrier from issuing a PIN. While we have the authority to withhold a PIN and payment to those physicians whose identify remains uncorroborated, we lack the necessary authority to protect beneficiaries who would be affected by our denial of a PIN and subsequent denial of payment for their claim.

For durable medical equipment suppliers (DME), there are currently no Federal licensure requirements for DME suppliers. The carrier will review the Office of the Inspector General's sanction list before assigning a provider number to a DME supplier.

Chairman PICKLE. I would like your recommendations. I would like for you to be more aggressive.

I know that you have problems. We observed earlier that if you pay claims too quickly, without really investigating them and running these appearance tests through PROs, then we, the Congress, hear about it and we fuss at you because you are dragging your feet and people are not getting their money.

If you pay them too quickly, then we are saying you are allowing fraud to happen. So you are caught. But getting a balance is the objective that we want you to have. I know that is what you want. Making claims and charges sometimes can get you in trouble. I understand that last week or sometime recently at least, Mr. Kusserow, your inspector general, was on a television show in which he made certain claims about certain doctors or types of doctors and they were false, they were incorrect apparently.

I understand that this evening at 6 o'clock the AMA is going to recommend to President Bush that he fire Mr. Kusserow. Now if that is the case, then of course that causes you as a bureaucrat to say, I am going to go slow in these cases. So it is not an easy procedure. But I will say to you that this committee feels that with respect to Medicare fraud, we are going to try to be more aggressive in this area in the next 2 years and work with the Health Subcommittee on the various aspects of Medicare fraud, we are going to put emphasis on it to see what we can do to prevent some of these claims.

So we have made that decision up here. That is going to be one of our primary areas. I think you ought to know that and we will work together.

In the meantime what I will ask you to do, if you have recommendations on changes that ought to be made, give them to us and let's don't wait until the get flushed out to the press. Maybe we can stay ahead of the criticism and have more fairness to the entire Medicare program. Otherwise, whenever you have a program of $100 million and it is going to grow, there are a lot of areas for fraud and you and I know it so we have to be as vigilant as possible.

Mr. Shaw, do you have any other questions?

Mr. SHAW. No, Mr. Chairman.

Chairman PICKLE. I want to say to you that I appreciate your cooperation in you coming up here. It looks like we are jumping on you because you allowed the Florida case to happen. They are happening, similar cases, all across this country. We know that. We have to try to close in on that kind of operation. But it does disturb us when you have a case where there has been obvious abuse, if not fraud, by some practitioners, the company is still in business and you are still doing business with them despite the fact that we can reasonably say that some $300 million has been paid out erroneously to this group.

Now that is not acceptable, is it? I just implore you to be as aggressive to us through your agency as you can so we can try to stay ahead of this.

We thank you for your cooperation. We appreciate your coming up on short notice and giving us your testimony.

The committee is adjourned.

[Whereupon, at 4:40 p.m., the hearing was adjourned.]

[A submission for the record follows:]

STATEMENT OF CONGRESSMAN FRANK ANNUNZIO

BEFORE THE SUBCOMMITTEE ON OVERSIGHT OF THE COMMITTEE ON WAYS AND MEANS

Mr. Chairman and Members of the Subcommittee, I want to commend you on holding these hearings on the subject of Medicare waste, fraud and abuse and other health issues. These are subjects of great importance to the citizens of my Illinois District. It will become even more serious if the increased payments and cuts in benefits contained in the proposed budget packages are enacted into law.

Health care costs have been rising at rates faster than the cost of living for at least the past two decades. This has created problems for the entire health care field, for employers and employees, for the Medicare and Medicaid programs, and for the elderly, the poor and disabled. For instance, while the Consumer Price Index increased by 23 percent from 1983 to 1989, medical care prices increased by 49 percent during the same time period, according to figures supplied by the Select Committee on Aging.

One of the prime reasons that the health care system in the United States, especially for the elderly, is critically ill can be traced to waste, fraud and mismanagement in the $100 billion-plus Medicare program. The reason can be found in the Reagan and Bush Administrations for the lack of oversight of the program by their regulators.

Congressional testimony has indicated that the Medicare program will overpay up to $1.5 billion next year because insufficient funds are being provided to audit doctor and hospital bills and monitor service patterns. And it appears the funding will decrease.

Health insurance fraud has become something of a national practice.

Insurance companies estimate that private and government insurers paid $60 billion last year for claims that were fraudulent or abusive, payments they say increase the cost of insurance for everyone, according to the NEW YORK TIMES. The spending amounts to ten percent of the $600 billion national health care budget.

Members of the Health Insurance Association of America, an industry group, investigated 19,600 cases of fraud last year, an increase of 60 percent since 1987. The increase, the group says, reflects both more fraud and intensified detection efforts.

There also was evidence that three percent of the nation's doctors routinely committed outright fraud, said the TIMES. But that probably is the tip of the iceberg. It is difficult to detect since the main source of information is the patient, who doesn't recognize the billing as fraudulent.

Some of the fraudulent acts are obvious thievery, like surgeons billing for operations they never performed. But some are common billing practices in which doctors and patients are willing co-conspirators.

As an example, a doctor may list a symptom covered by the insurance as the reason for an office visit so the carrier will pay, or falsify the date on which a service was performed so that it will fall within a policy's coverage date.

Insurance companies, during the past five years, have started ambitious campaigns to root out offenders, complete with computerized fraud detection systems and toll-free hot lines for patients to report their doctors. They concede it has been difficult.

Among the many fraudulent and abusive practices condemned by insurers, forgiveness of co-payment has become the most controversial. Most private insurance policies, as well as Medicare, require a patient to pay part of his medical bill, usually 20 percent. Although only 14 percent of the cases investigated by the Aetna Life Insurance Company's fraud unit last year involved forgiveness, insurers suspect the practice is often unreported and probably epidemic.

Insurers say that money lost by waiving co-payment is often recouped by claiming higher rates. Studies of California dentists have shown that those who routinely forgive co-payments set their base fees 25 percent higher than other dentists and perform dramatically more elective procedures, like full mouth X-rays and crowns.

Potentially fraudulent billing practices are particularly rampant in areas where there is an oversupply of doctors or where prepaid plans like health maintenance organizations have squeezed traditional private practitioners, according to experts.

Last year, 323 health providers were convicted in cases involving private insurance fraud, and 138 for fraudulent activities involving Medicaid and Medicare, a number that has grown with each succeeding year, according to the Department of Health and Human Services.

Private insurers are not only losing money through waste, fraud and abuse, but they are spending an increasing amount of money to make sure doctors' and hospitals' bills are appropriate. The effort saves billions of dollars annually, according to the Health Insurance Association of America.

And, says Robert Brandon, Vice President of Citizen Action, an advocacy group for national health insurance, competition in the insurance market is wasteful and expensive. In health care, said Brandon, a free market cannot work. He said there is a need for a single-payer system where the government is the sole insurer.

Citizen Action released a report recently in which it said commercial insurance companies spend 14 times as much as the Medicare program does on administration, overhead and marketing. And private sector insurers spent 11 times as much per dollar of claims paid as the Canadian national health care system, according to the group.

The report showed that in 1988, commercial health insurance companies spent 33.5 cents on administration, marketing, commissions and other overhead expenses for every dollar in claims paid out. By comparison, Medicare's administrative costs were 2.3 cents per dollar in claims paid out. In the Canadian health care system, administrative costs amount to about 3 cents per dollar in claims paid.

The study found that if the private health insurance industry were as efficient as Medicare, about $13 billion could be saved to provide insurance to 11 million uninsured people.

Recently, a Congressional commission released a report on providing health insurance to the 31 million Americans who do not have it and creating a universal long-term care program, one that would cost about $69.6 billion or an additional $8.25 a week ($430 a year) in Federal taxes for every non-poor adult.

The U.S. Bipartisan Commission on Comprehensive Health Care, better known as the Pepper Commission for its first Chairman, the late Representative Claude Pepper (D-Fla.), made no financing recommendations but included six potential finance packages as possibilities.

Under the commission's plan, basic health insurance would be assured to all persons by requiring employers to provide it or pay a tax. Anyone not covered by an employer could buy into a government health insurance program, or if poor, enroll in it free or at reduced costs.

The six funding options examined by the commission include:

-Increasing the Social Security payroll tax by 0.95 percent each on employers and employees to raise $44.7 billion. Another $25.3 billion would come from tax increases on payrolls, cigarettes, beer, wine and inheritances.

-Relying primarily on a four percent value-added sales tax - with certain exemptions - to raise $72 billion. About one-fourth of that amount would come from new income taxes on Social Security benefits, top-income taxpayers and on the insurance value of employer-provided health care.

-Getting $37 billion by raising the top income tax rate to 33 percent and collecting the remainder of a $70 billion fund by making everyone pay a seven percent income surtax, increasing cigarette, beer and wine taxes and taxing capital gains at death.

-Imposing a new, additional 4.5 percent tax on all personal income above $16,000 ($32,000 for a couple) to raise $75 billion.

-Raising $41 billion through Social Security payroll taxes on all job earnings above the current $51,300 annual limit and $30 billion more from new cigarette, beer, wine and capital gains taxes.

-Raising $33 billion by increasing the Social Security payroll tax by 0.80 percent each on employers and employees, $12 billion from increasing top income tax rates to 34 percent and $26 billion from other changes.

I personally do not favor any of the proposals because each would place a heavier burden on the "little guy," especially senior citizens. I believe the funds for a national health program can be found by cutting other programs, such as the Defense Department which is rife with waste and abuse and mismanagement.

In addition, the House and Senate will soon be asked to approve a budget for 1991 which will include the first step in cutting the $500 billion deficit over the next five years. Most of the tax increases suggested by the Pepper Commission will be included in the budget proposals that Congress will consider.

I voted against the proposal agreed to by the so-called Budget Summiteers because Medicare would have been cut by $60 billion over the next five years, with half the reduction coming in government payments to doctors and other health care providers and the other half coming through higher premiums and deductibles for the 33 million elderly citizens covered by the program. I want to study the proposals coming out of the House Ways and Means and Senate Finance Committees before I decide whether to accept them or not.

Mr. Chairman, and Members of the Subcommittee, I want to thank you for permitting me to express my views on Medicare and a national health policy.

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